

South African Medical Journal



S.-A. Tydskrif vir Geneeskunde

Organ of the Medical Association of South Africa

Blad van die Mediese Vereniging van Suid-Afrika

Incorporating the South African Medical Record and the
Medical Journal of South Africa

Waarby ingelyf is die South African Medical Record and the
Medical Journal of South Africa

Registered at the General Post Office as a Newspaper

By die poswese as nuusblad geregistreer

Cape Town, 30 October 1954
Weekly 2s. 6d.

Vol. 28 No. 44

Kaapstad, 30 Oktober 1954
Weekliks 2s. 6d.

IN THIS ISSUE—IN HIERDIE UITGAWE

Editorials: Van die Redaksie

Diabetes and Pregnancy
Suikersiekte en Swangerskap
Practitioners in the British National Health Service

Original Articles: Oorspronklike Artikels

Medicine is a Calling
Silicosis in Secondary Industry
Arteriography and Aortography in Peripheral Vascular Disease
Surgical Treatment of a Case of Wry-Neck
The Management of Varicose Veins

Medicine in the Cape in the Early Days of the Century

Papers Presented at the Research Forum, Cape Town

Association News: Verenigingsnuus (Meeting of Griqualand West Branch)

Die Suid-Afrikaanse Geneeskundige en Tandheelkundige Raad (Verslag van Onderzoek na die
Gedrag van Dr. N.K.)

Passing Events: In die Verbygaan

Correspondence: Briewerubriek

Reviews of Books: Boekresensies

Support Your Own Agency Department
Ondersteun u Eie Agentskap-Afdeling
Professional Appointments
Professionele Betrekkings

(P. xxii)
(Bl. xxii)
(Pp. xxii-xxvi)
(Bl. xxii-xxvi)

**When there is
danger in
simple
things**

Unseen dust in the air; allergens in food; that friendly dog from next door — these are but a few of the simple things that may well bring discomfort and illness to the hypersensitive.

When allergic or sensitivity reactions occur, rapid and effective symptomatic relief may be obtained with one of the **M&B** brand antihistaminics.

Supplied in the form of tablets, elixir, solution for injection, and cream.



MA2127

MANUFACTURED AND DISTRIBUTED IN SOUTH AFRICA BY
MAYBAKER (S.A.) (PTY.) LTD · P.O. BOX 1130 PORT ELIZABETH TEL. 89011 (3 LINES)

five simple ways to take Rubraton:

with a half glass of water



with a half glass of milk



with a half glass of fruit juice



with a half glass of ginger ale



or just straight from the spoon



no matter which way it's taken...

it is the blood-building elixir that always tastes good!

The Rubraton Formula	1 teaspoonful (5 cc.) supplies:	1 teaspoonful t.i.d. (15 cc.) supplies:
Vitamin B ₁₂ activity	4.17 mcgm.	12.6 mcgm.
Folic Acid	0.28 mg.	0.84 mg.
Ferric Ammonium Citrate	220 mg.	660 mg.
supplying elemental iron	38 mg.	114 mg.

Alcohol content: 12 per cent

Further Information and Literature is available from:

Protea Pharmaceuticals Limited

7 Newton Street, Wemmer, Johannesburg.

P.O. Box 7793

Telephone 33-2211

Also at Cape Town, Port Elizabeth, East London and Durban.

In anemia: 1 or 2 teaspoonfuls t.i.d.

For promotion of growth: 1 teaspoonful t.i.d.

Bottles of 4 oz. and 16 oz.

RUBRATON

SQUIBB IRON — B₁₂ — FOLIC ACID ELIXIR

SQUIBB

RUBRATON T.M.

Chain Reaction

ANEMIA

***anorexia-malnutrition
aggravated anemia-anorexia
in a degenerating cycle***

To break this vicious chain reaction—
more than iron is required.

Supplying generous amounts of
vitamin B₁₂ together with iron, liver
and important factors of the B
complex, Livitamin aids in
maintaining the appetite and normal
gastrointestinal function.

Livitamin is well tolerated
and may be given to children
as well as to adults.

This complete approach
to hypochromic anemia produces
gratifying and prompt improvement
in both the blood picture and
clinical manifestations.

LIVITAMIN

Supplied in 8 fl. oz. bottles
Dosage—Adult: One Tablespoonful t.i.d.
Children: In proportion to age

S.E. Massengill

Bristol, Tennessee

Distributors: Westdene Products (Pty.) Ltd., 22-24 Essanby House, 175 Jeppe Street
P.O. Box 7710 Johannesburg Telephone 23-0314
CAPE TOWN: 211 CTC Buildings, Corporation Street, Phone: 2-2276. PRETORIA: 222 Central House, Central Street, Phone: 3-3487
DURBAN: 66/67 National Mutual Buildings, Gardiner Street. Phone: 2-4975



НБ НБ НБ НБ НБ

FIRST in SECONDARY ANAEMIAS

HAEMATOGEN HOMMEL

НБ НБ НБ НБ НБ

In microcytic anaemias — chlorotic, postoperative, haemorrhagic — the therapeutic aim is to increase the number and haemoglobin value of the erythrocytes.

For rapid haematinic effect, 'Haematogen'-Hommel, produced by refinement of actual whole blood and comprising haemoglobin, albumin and iron, is a rational replacement therapy in the above-mentioned blood deficiency states. It is also valuable in correction of mal- or sub-nutrition and in convalescence.

★ **'HAEMATOGEN'**-Hommel is presented in semi-fluid form, for immediate and acceptable administration to children and adults.

FORMULA — Active constituents: *Haemoglobin 17.5%, Albumin 7.5%.*

PACKING — Bottles of 8 fluid ounces.

HOMMEL'S HAEMATOGEN & DRUG CO.
121 NORWOOD ROAD, LONDON S.E.24



Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Haemoglobin (%)	65	68	72	75	78	80	82	83	84	85	85	85	85	85

Our Sole Agents for SOUTH AFRICA :— Messrs. LENNON LIMITED
P.O. Box 39. CAPE TOWN • P.O. Box 24. PORT ELIZABETH • P.O. Box 266. DURBAN, NATAL
P.O. Box 928. JOHANNESBURG, TRANSVAAL • P.O. Box 76. EAST LONDON
P.O. Box 1102. BULAWAYO, Southern Rhodesia • P.O. Box 379. SALISBURY, Southern Rhodesia

South African Medical Journal
Suid-Afrikaanse Tydskrif vir Geneeskunde
P.O. Box 643, Cape Town Posbus 643, Kaapstad

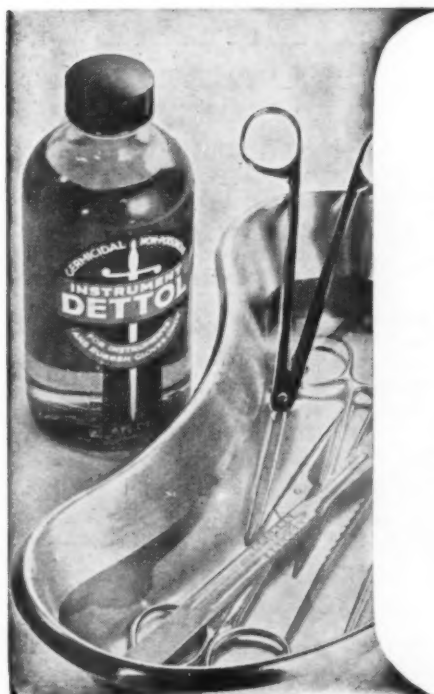
Cape Town, 30 October 1954
Weekly 2s. 6d.

Vol. 28 No. 44

Kaapstad, 30 Oktober 1954
Weekliks 2s. 6d.

CONTENTS — INHOUD

Medicine is a Calling: Presidential Address by L. E. Lane, F.R.C.S. at adjourned Annual General Meeting of the Association, Pretoria, 28 October	921	Die Suid-Afrikaanse Geneeskundige en Tandheelkundige Raad (Verslag van Ondersoek na die Gedrag van Dr. N.K.)	930
Silicosis in Secondary Industry. M. A. Pringle, M.B., B.Ch.	924	Revision Series — III. The Management of Varicose Veins. D. J. du Plessis, M.Ch., F.R.C.S.	931
Editorials: Van die Redaksie		Medicine in the Cape in the Early Days of the Century. A. Simpson Wells, M.B., M.A., M.D., F.R.C.S.	934
Diabetes and Pregnancy	925	Papers Presented at the Research Forum, Cape Town	936
Suikersiekte en Swangerskap	925	Association News: Verenigingsnuus (Meeting of Griqualand West Branch)	936
Practitioners in the British National Health Service	926	Passing Events: In die Verbygaan	936
Arteriography and Aortography in Peripheral Vascular Disease. M. A. Loutré, F.R.C.S.	927	Reviews of Books: Boekresensies	937
Surgical Treatment of a Case of Wry-Neck. Jack Penn, F.R.C.S. and Wilfred Kark, F.R.C.S.	929	Correspondence: Briewerubriek	938



For storing and disinfecting surgical instruments, rubber gloves, sutures and other apparatus used in the operating theatre.

Quick and effective action

Its action is lethal to a wide range of pathogenic micro-organisms of which the following are but a few examples. When diluted with distilled water, it destroys "in vitro" in 10 minutes at 20°C:

<i>Bact. coli</i>	1-250	<i>Ps. pyocyanea</i>	1-100
<i>Sh. dysenteriae</i>	1-225	<i>Bact. typhosum</i>	1-300
<i>Strep. pyocyanea</i>	1-300	<i>Staph. aureus</i> (U.S.A. FDA type 209)	1-120

Clear solution

Instrument Dettol provides a clear solution when diluted with soft or distilled water or surgical spirit. Available in 8 oz. and 80 oz. bottles.

Instrument DETTOL

For free sample and literature write to
Reckitt & Colman (Africa) Limited, P.O. Box 1097 Cape Town.

Please Support Our Advertisers — Ondersteun Asseblief Ons Adverteerders

Rheumatoid Arthritis

" . . . to obtain maximal objective signs of improvement in articular function while receiving safe, suppressive doses of cortisone, it is essential to utilize a program of treatment that includes physical medicine"¹

The above quotation is taken from a recent report in the Journal of the American Medical Association giving comparative results of treatment of two groups of patients hospitalized with rheumatoid arthritis.

The physical medicine used in this study consisted of salicylates, proper diet, adequate rest and, in some instances, special articular supports.

Salicylate therapy . . . used with the control group of 34 patients . . . achieved a "marked or moderate" improvement of 80%. When Cortisone was administered simultaneously with salicylates to a group of 54 patients a slightly better result . . . only 5% better . . . was recorded.

When it is remembered that rheumatoid arthritis (the only arthritic disorder for which cortical hormones are indicated) accounts for an extremely small proportion of those afflicted with arthritic and rheumatic disorders, the proved effectiveness of salicylate therapy takes on added importance.

Confirmation of the value of salicylate therapy has been provided by clinical tests in Great Britain and Canada using the BERMIDE formula. This is of particular interest to South African physicians now making the "BERMIDE TEST"

BERMIDE oral therapy may be freely prescribed for osteoarthritis, infectious and rheumatoid arthritis as well as for rheumatism, rheumatic fever and various forms of neuritis and sciatica. BERMIDE is well tolerated . . . safe for prolonged administration . . . relieves symptoms promptly . . . controls metabolic disturbances . . . restores normal physiological action . . . and BERMIDE is moderate in cost.

¹Gordon, M. Martin; Polley, Howard F.; Anderson, Thomas D.; *Physical Medicine Plus Cortisone for Rheumatoid Arthritis*, J.A.M.A., vol. 148, No. 7, February 16, 1952.

THE "BERMIDE TEST"

*The Pan Pharmacals Company is offering supplies of BERMIDE—gratis—to physicians for them to make their own "BERMIDE TEST" with two patients suffering from Arthritic or Rheumatic disorders.

On receipt of a request from you, we will send you the large-size dispensing bottle of 500 BERMIDE tablets with complete recommendations for dosage. Additional supplies will be furnished as required.

BERMIDE is manufactured under licence and is the trademark of this product.

Bermide

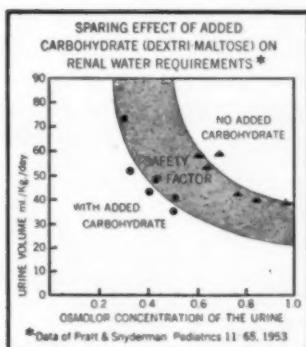
THE PAN PHARMACALS COMPANY
P.O. BOX 427 — JOHANNESBURG

BER. 3

DEXTRI-MALTOSE

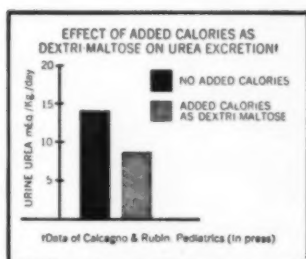
formulas

**provide important
physiologic safeguards**



Added renal safety. When the effective carbohydrate, Dextri-Maltose®, is added to cow's milk formulas, the infant's water requirements are reduced. This provides an added margin of safety against dehydration. In addition, the load on the water excretory capacity of the infant's immature kidneys is reduced.^{1,2}

The margin of renal safety is especially important since various stresses and handicaps have been shown to influence the infant's fluid balance and renal capacity.^{1,3,4,5}



Better nitrogen retention. The addition of adequate carbohydrate (Dextri-Maltose) to cow's milk formulas increases the infant's nitrogen retention and promotes the efficient use of nitrogen for growth,² causing a reduction in the excretion of urea and lightening the load on the infant's kidneys.

Ample carbohydrate is provided in a milk and water mixture by inclusion of 4 to 5% of Dextri-Maltose—or 1 tablespoonful to each 5 or 6 fluid ounces of formula.

With a record of forty-three years of outstanding clinical success, no other carbohydrate has earned such world-wide acceptance and confidence in its constant dependability as Dextri-Maltose.



1. Pratt & Snyderman: Pediatrics 11: 65, 1953; 2. Calcagno & Rubin: Pediatrics (in press); 3. Calcagno, Rubin & Weintraub: J. Clin. Investigation 33: 91, 1954; 4. Cooke, Pratt & Darrow: Yale J. Biol. & Med. 22: 227, 1950; 5. Gamble: J. Pediatr. 30: 488, 1947; 6. Rappaport: Am. J. Dis. Child. 74: 682, 1947.

DEXTRI-MALTOSE

the carbohydrate of choice for infant formulas

MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA, U.S.A.

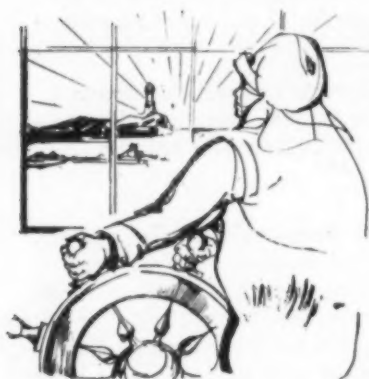
MEAD



consider the
promise
 of **Tetracyn***
brand of tetracycline

newest broad-spectrum antibiotic

*Tetracyn is being made available in
 a variety of convenient dosage forms.*



consider the
proof
 of **Terramycin***
brand of oxytetracycline

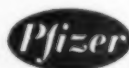
unexcelled broad-spectrum antibiotic

*whatever the clinical
 condition... whatever
 your therapeutic
 preference... there is
 a Pfizer agent for every
 antimicrobial indication*

TERRAMYCIN*
(brand of oxytetracycline)

BACITRACIN
 COMBISTIC*
 COTINAZIN*
 DIHYDROSTREPTOMYCIN
 MAGNAMYCIN*
 PENICILLIN
 PERMAPEN*
 POLYMYXIN
 PRONAFEN*
 STREPTOMYCIN
 STREPTOHYDRAZID*
 VIOGIN*

TETRACYN*
(brand of tetracycline)



World's Largest Producer of Antibiotics

VITAMIN-MINERAL FORMULATIONS
 HORMONES

Distributors: PETERSEN LTD. P.O. Box 38, Cape Town. P.O. Box 5785, Johannesburg. 113, Umbilo Road, Durban, South Africa.

PFIZER LABORATORIES (SOUTH AFRICA) (PTY.) LTD., P.O. BOX 7324, JOHANNESBURG.

170,000 HYPERTENSIVES

It is estimated that there may well be this number of European Hypertensives in the Union. The number of African sufferers is unknown but the percentage will be high among the de-tribalised types, striving to adjust to the pace of modern industrial life in urban surroundings. Returning to the Europeans, there must be an average of about 28 Hypertensive subjects to every practising Doctor. If only one quarter present themselves for treatment you probably have at least half a dozen on your books.

EACH ONE PRESENTS AN INDIVIDUAL PROBLEM, BUT EFFECTIVE THERAPY IS NOW SELECTIVELY AVAILABLE TO MEET THE PARTICULAR REQUIREMENTS OF EVERY CASE.

Veriloid

For positive hypotensive action orally or parenterally.

Veriloid-VP

To replace oral veriloid where higher dosage levels are indicated or where side effect of nausea is present.

Rauwiloid

Mild, long-acting hypotensor with added calming and bradycardic action.

Rauwiloid + Veriloid

For positive hypotensive effect under direct control of clinician *plus* rauwolfia virtues in addition.

Rauwiloid + Hexamethonium

Powerful, immediate acting hypotensor where the situation is judged to justify ganglionic blockade.

Further information available from:

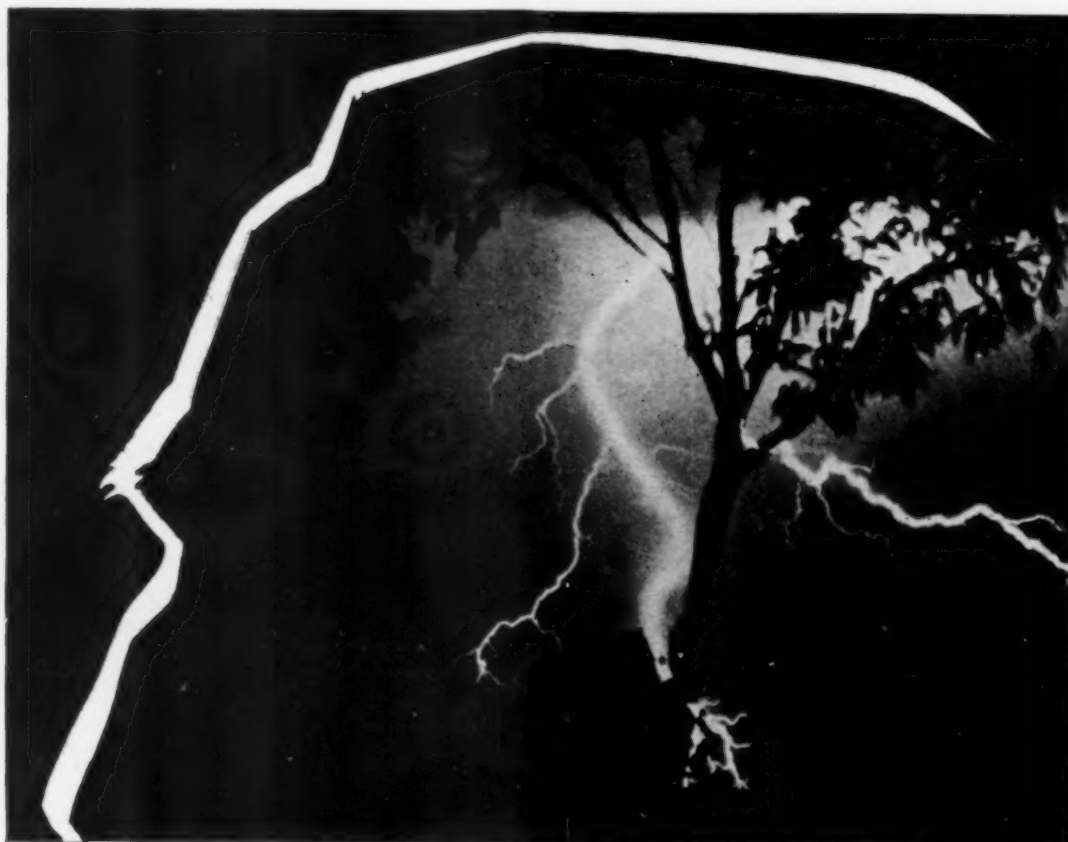
3377-3

RIKER LABORATORIES AFRICA (PTY.) LTD. P.O. Box 1355, Port Elizabeth

LOS ANGELES

TORONTO

LOUGHBOROUGH



EPILEPSY *the effective control of all attacks and disturbances*

"MYSOLINE" is active in all forms of epilepsy, especially grand mal and psychomotor types. It may also be used with advantage in some cases of petit mal.

- ★ High anticonvulsant activity.
- ★ Low toxicity.
- ★ Low hypnotic effect with established treatment.
- ★ Beneficial effect on mental outlook and general well-being of patient.

'MYSOLINE'

PRIMIDONE

TRADE MARK

A NEW ANTICONVULSANT



IMPERIAL CHEMICAL (PHARMACEUTICALS) LIMITED

WILMSLOW, MANCHESTER

(A subsidiary company of Imperial Chemical Industries Limited)

Distributed by:

I.C.I. SOUTH AFRICA (PHARMACEUTICALS) LIMITED

Pan Africa House

75 Troye Street

P.O. Box 7796

Johannesburg

Phe25

South African Medical Journal Suid-Afrikaanse Tydskrif vir Geneeskunde

P.O. Box 643, Cape Town

Posbus 643, Kaapstad

Cape Town, 30 October 1954
Weekly 2s. 6d.

Vol. 28 No. 44

Kaapstad, 30 Oktober 1954
Weekliks 2s. 6d.

MEDICINE IS A CALLING*

L. E. LANE, F.R.C.S. (EDIN.)

Port Elizabeth

I am conscious of the importance of this occasion and I am very honoured to be in the position in which I now find myself.

I trust that you will bear with me in the subject that I have chosen for my address for, whatever my inadequacies in presentation may be, the subject matter must surely be worthy of your thoughts and consideration.

Medicine is a calling. It has a great past and has much to contribute to the future. In this age of materialism and scientific advance we are perhaps inclined to place a wrong emphasis on values and lose sight of fundamentals which are basic to our well-being and progress.

Life is Short and Art is Long. So turning back the pages of history to the Father of Medicine we find the Hippocratic code which we regard as our charter, containing the very essence of what can still be considered the highest of ethics and the guide to professional conduct. Although Hippocrates was responsible for the separation of medicine from the religion of his day, it is clear from his writings that he was inspired by a deep sense of religion. Before this period, the art of medicine was probably first cultivated in

Egypt, where the offices of priest and physician were combined in the same person. In the writings of Moses there are several references to the practice of medicine

amongst the Jews. The priests were the physicians and their treatment mainly aimed at promoting cleanliness and preventing contagion.

From earliest times it is seen that the practice of medicine has been in close association with the Church and that it has been governed by high moral and ethical standards. It is a notable fact that a large proportion of our Lord's ministry was devoted to healing the sick. One of the Evangelists was known as the 'beloved physician'. This recognition of St. Luke as a physician is significant in that it draws a distinction between the spiritual and human aspects in the art of healing, but it does not dissociate the two. Is not the one complementary to the other?

We all know how difficult recovery is in a patient who has lost hope. We are also familiar with the common expression that the patient has lost confidence in his doctor. Is this due to lack of scientific knowledge and medical skill? More often, I venture to say, it is the

doctor's approach—lack of human understanding and appreciation of the many complexities surrounding the sick bed—which loses him the faith and confidence of the



Dr. L. E. Lane, President, Medical Association of South Africa, 1954-55.

* Presidential Address delivered at the adjourned Annual General Meeting of the Association, Pretoria, 28 October 1954.

patient. Charity has been a driving force in the medicine of the past and is still basic in the human relationship between the doctor and his patient. It is right that we should place a high premium on knowledge and that we should demand a high standard from our graduates; but I cannot believe that these are the sole essentials of a good doctor.

I recall a discussion which 2 years ago I was privileged to have with a distinguished Edinburgh surgeon who has for many years been attached to the Royal Infirmary and the examining bodies. The question of the selection of medical students arose and I told him that in this country it was difficult for any but first-class matriculants to obtain admission to a medical faculty. To this his only reply was, 'What a number of good doctors you must lose'. It is pleasing to find that this method of selection of medical students has at least been modified, for when I look back over the years and see the valuable contributions made to our profession by many of my colleagues who were only second-class and even third-class matriculants, I find myself posing the question of their success. Is not the answer to be found in their background—common-sense and practical approach, fortified with a real sense of vocation?

Here I would like to make a plea for a broader, more cultural practical and less specialized approach in the training of our medical students. If the general practitioner is to remain the backbone of the profession, then his education should envisage and primarily concern itself with the many facets of general practice, and a reasonably large part in it should be undertaken by suitably qualified doctors experienced in the hard mill of general practice. It is argued that the scientific side of the training would suffer. This is open to debate. Already the 6-year curriculum is overloaded. Instead of trying to crowd an ever-increasing amount of scientific data into the basic training, we should rather concentrate on the broad fundamental principles on which to build and consolidate the practice of medicine. The newly-qualified houseman of today is certainly armed with an impressive amount of theoretical knowledge; but judging from his experience of simple and everyday procedures of general and hospital practice, it is only too evident how essential is the 12 months of compulsory internship. It is already apparent that this period could with advantage be extended.

Returning again to history, it is said that Hippocrates raised medicine to the rank of a learned profession and that Celsus praised Hippocrates for having made medicine a branch of science. Since then, argument has never ceased as to whether medicine is basically a science or an art. There is much to be said for those who favour medicine as an art—the art of healing—for what we want at a patient's bedside is a doctor, not a scientist; an expert craftsman in his art, with all the sense of good craftsmanship and the reverence which the art should inspire.

We can look back with pride on our achievements of the past, from the time, 3 centuries ago, when William Harvey put forward his observations of the *Circulation of the Blood in the Body*, and by so doing shattered the beliefs of a thousand years. Progress in the scientific field has been truly amazing. Pasteur's discovery of the

foundations of bacteriology opened up to medical science knowledge of the cause of many diseases, and enabled Lister to do his great work on surgical sepsis; aseptic surgery was soon to follow, and this laid the foundation for great advances, which with later improvements in anaesthesia and modern antibiotic therapy, gives a vastly extended scope for operative skill. The days when the pulse rate, thermometer and stethoscope were the main equipment of the doctor have now long passed. In those days it was not uncommon to find strong opposition by members of the medical profession to any new method of examination or treatment, whilst the public generally viewed these innovations with distrust. Laennec's introduction of the stethoscope was not accepted for many years and at a later period there was strong opposition to X-ray examination.

How times have changed! The pendulum has perhaps swung too far the other way. Science has contributed so much to medical thought, practice and behaviour, that it is impossible for any doctor to keep abreast of all the latest developments in his profession; the public on the other hand make demands for new preparations, X-ray examinations, investigations and specialist services which are quite often unnecessary.

THE FAMILY DOCTOR AND THE SPECIALIST

Dr. W. N. Pickles, President of the British College of General Practitioners, in his message to the inaugural meeting of the College of General Practice of Canada, said: 'On the shoulders of the family doctor rests the care of the people'. With this there can be little disagreement; we must accept our responsibilities and, as custodians of the nation's health, see that our shoulders are broad enough to carry them.

The specialist is an essential and integral part of every scientific field and in our profession we should be turning the clock back if we did not recognize the importance of his contribution. There are certain specialist fields where the practitioner who for health or other personal reasons cannot measure up to the high standards and demands of general practice can still usefully find scope and reward for his labours; but the main incentive to specialize should be a true thirst for knowledge, and an urgent desire to pursue and perfect a particular branch of medicine.

It does not follow that a good family practitioner would necessarily make a good specialist; many would in fact be most unhappy away from the intimate contact and confidence which are found in the family circle. In some of the specialities the service is a much less personal one, and the doctor-patient relationship, which is all-important in general practice, bringing rich rewards, is developed to a far less extent. On the credit side, however, a new and broader contact has been created—the doctor-patient-specialist relationship. This young but legitimate conception has not yet reached full maturity, and it is therefore still suspect. It would be strange if this were not so, and we need not be unduly alarmed about it. 'The old order changeth, yielding place to new'; there are many ways in which medicine must expand and fulfil its obligations.

In specialization the emphasis must be on proper and adequate training, ability and skill. These are major requirements if these services are to fulfil their purpose and maintain the respect and confidence of the public and the profession. A specialist, however, is still first and foremost a doctor, and if it is his calling that inspires and directs his efforts to know 'more and more about less and less', then there should be no fear about the value of his contribution. But one so often hears a younger medical man express the view that he intends specializing because he does not want to endure the hardships of general practice; the doctor's wife, quite reasonably and naturally, tires of answering telephone calls and thinks that her husband would have more leisure for both himself and his family if he specialized. Then again the older and more mature practitioner gives up his hard but happy and well-established practice, in the hopes that he may join the ranks of those who work to more regular hours and even perhaps be better off financially. These are not firm rocks on which to build, and whilst there may be much to be said for this prospective type of specialist, we should at all times remember our precepts, try and assess our capabilities, and render service how best we can, without allowing the hours of toil or the fruits of reward to be the deciding factors.

I am reminded of the motto of my alma mater, Guy's Hospital: *dare quam accipere*—it is better to give than to receive. I feel that we have all been giving something to our neighbour ever since we entered this noble profession; let us then continue to give, and give of our best, how best we can. Yet 'the labourer is worthy of his hire', and in this world of material values, it is only right that a doctor should receive a just reward for his services, so that he may be able to meet his responsibilities honourably and without embarrassment.

HEALTH SERVICES

In Britain, the health services of the nation as well as the individual have been made a Government responsibility, and a National Health Service has been brought into being. This is indeed a proud achievement and a wonderful endeavour, to provide better health services for all, at the same time relieving the doctor of financial worries. It is a practical realization and acceptance by the State of its health responsibilities to the nation, but time alone will show whether the security it offers to the doctor will be as good a stimulus to give of his best as the old conditions of practice in which our seniors worked, whose example we try to emulate.

In our country, an enormous amount has been done to improve all sections of the health services and, with the rapid and greater development of medical aid and benefit societies, an increasing proportion of the population is being well catered for, at the same time leaving the greatest possible freedom of choice of doctor, and assuring him of a fair reward for his services. These are great achievements, and this Association can be justly proud of the part that it has played in their development and application.

I do not believe, however, that a doctor can ever be adequately rewarded for his services, nor should he

expect to be so rewarded. On the other hand, our endeavours to obtain recognition and security should not be misjudged or exaggerated, whilst we in our turn must not be influenced by materialism, but by a greater love for our calling and a sincere desire to improve our skill and make our services available to all sections of the people, with due regard to the economic structure of the country as a whole.

THE PAST AND FUTURE

It seems clear that even in this 'atomic age' we have every reason to be proud of the advances which medicine in its many spheres has made; the public and the State are also becoming more and more health-conscious and are prepared not only to co-operate with us in providing a better and more comprehensive health service but, more than ever before, are appreciative of their financial responsibilities.

There is no doubt that scientifically we shall continue to advance and add lustre to our achievements of the past, but if we should do all this, and lose the nation's faith and trust in us as a profession, then the hopes which our precepts have engendered throughout the ages will be forfeit; our future will be doubtful and we shall be forced, more and more, to seek security by enactments and entrenchment of our so-called rights. We have always had our problems, we seem to be having them at present, and we shall without doubt, continue to have them in the future. The fact that we are alive to them is a healthy sign; the machinery of this Association gives the fullest scope for the individual member's expression of opinion on all matters pertinent to his welfare. If these democratic rights are not exercised it is impossible for those in authority to interpret the views of the profession. There is no room for complacency and I would stress the importance of the fullest discussion of our medical problems by every member within our Association.

I have on many occasions, and recently more than ever, cast my mind back to my youth and over the years, pondering the most probable reason for my having become a doctor. I always arrive at the same conclusion, that it was the example of our family doctor, and that it was he who inspired me to want to be like him and do like him. During my student days and in subsequent years, it has been the example of my teachers and colleagues which has impressed me most profoundly. Example and confidence in the preponderating goodness of human nature were corner-stones in the philosophy of Confucius, and the passing of time has only served to enhance their wisdom and importance. Our profession has an abundance of good example, and its richness has been endowed for all time by the example of the Greatest of all Healers.

It is only too evident that we doctors have a challenge to meet and that we must face up to this challenge. Our effectiveness in the community, the nation and the world at large is dependent upon our prestige in the eyes of the public. We cannot retain high prestige unless we place greater emphasis than we do at present on the well-founded ideals of our profession. In my view we have no option in the matter. The public whom we

serve will demand action on our part, and if we are realists, we shall anticipate the demand and not have it forced upon us.

In taking stock of ourselves we must guard against preoccupation with personal and financial gain, for *this* is materialism, and will tend towards our undoing.

Some virtue will pass out of our art of healing. For medicine is an art before it is a science; and it is also a vocation. If in applying ourselves to this art we are not actuated by the false motives I have mentioned, then we can with confidence claim that we are rightly responding to our calling.

SILICOSIS IN SECONDARY INDUSTRY

CASE REPORT

M. A. PRINGLE, M.B., B.Ch.

Medical Superintendent, Chamber of Mines (Springkell) Sanatorium

Silicosis in South Africa is a well-recognized disease, hitherto occurring chiefly in workers on the Witwatersrand gold mines. Cases have been seen amongst other miners, workmen associated with drilling operations for sewers, drill sharpeners, stonemasons, etc., but the case reported in this article is the first of its kind attributed to another occupation than gold mining which has been admitted to the Chamber of Mines (Springkell) Sanatorium.

CASE REPORT

European male aged 41 years. Employed on the Witwatersrand gold mines from 1927 to 1941, during which period he worked underground for about 8 years. He left the mines voluntarily because of 'bronchitis', at which time the X-ray of his chest was normal. Subsequently he was employed for 4 years 11 months in 1943-1947 as a foreman in a mill grinding quartz for the manufacture of scouring powders or like substances. Between 1947 and the time of his admission to the Sanatorium on 18 January 1950, he had a few industrially innocuous odd jobs.

On admission the patient complained of gradually increasing dyspnoea, productive cough, pain in the 'lung' and loss of 10 lb. in weight over a period of about 3 years. The sputum was occasionally flecked with blood.

On examination he appeared well nourished, but had a sallow complexion with obvious cyanosis and dyspnoea. There was poor movement of the chest with impaired air-entry and rhonchi. X-ray revealed gross bilateral, scattered opacities, confluent in places and interspersed with patchy emphysema (Fig. 1). The appearances were not unlike those of a widespread chronic inflammatory condition or carcinomatosis, but this was not consistent with his general condition and, because of the history, a tentative diagnosis of pneumoconiosis with or without infective changes was made.

The following investigations were carried out: Numerous sputum tests were negative for tubercle bacilli, fungi (except for a monilia in one sputum, parasites and talc bodies. Atypical hyperchromatic cells were noted on two occasions, suggesting the possibility of a neoplasm. E.S.R. was 8 mm. (Westergren). Modified Ide test and other laboratory investigations were negative. Bronchoscopy gave normal results. Antibiotic therapy (penicillin, aureomycin and streptomycin) caused no apparent change in his condition.

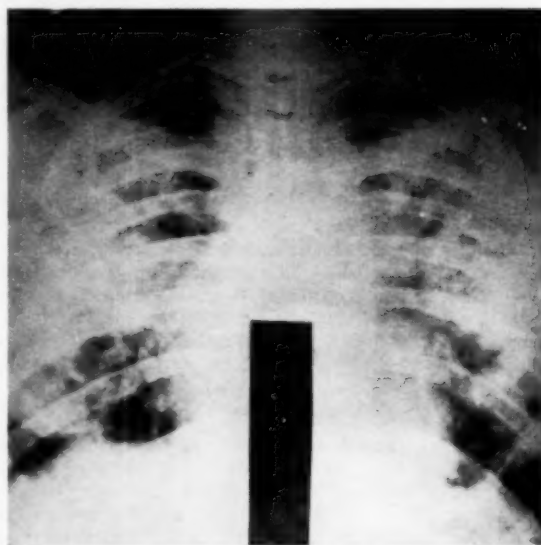


Fig. 1

The patient was discharged on 12 May 1950 with a diagnosis of sub-acute and extensive silicosis, apparently contracted after leaving the mines and while working in a silica-grinding plant. He died on 11 November 1950, and the diagnosis was then confirmed at autopsy.

This case exemplifies the necessity for a careful occupational history and its correlation with clinical findings, and for remembering that silicosis and other pneumoconioses occur outside the mining industry and will probably be seen with greater frequency with the development and expansion of secondary industries.

Steps should be taken to provide protection and compensation for workers engaged in similar hazardous occupations.

CORTOGEN IS CORTISONE

and now
introducing

CORTOGEN-F

hydrocortisone - free alcohol
the most potent form
of hydrocortisone

TABLETS and CREAM

CORTOGEN-F TABLETS (hydrocortisone - free alcohol)
10 mg. and 20 mg. (both scored)
Bottles of 25

CORTOGEN-F CREAM (hydrocortisone - free alcohol)
1% for topical administration
Tubes of 5 grams

Schering

CORPORATION • BLOOMFIELD, N.J.

Scherag (Pty.) Ltd. — P.O. Box 7539 — Johannesburg



CODIS

regd.

a marked improvement upon

TAB. CODEIN. CO. B.P.

Aspirin, phenacetin, codeine phosphate; there is no more familiar group of analgesic drugs. 'Codis' improves upon it. In Codis the 'aspirin' is soluble, as in 'Disprin', and rapidly forms a solution of palatable calcium aspirin.

A Codis tablet placed uncrushed in water provides, in a few seconds, a solution of calcium aspirin and codeine phosphate, with phenacetin in fine suspension.

The advantages of analgesic therapy with Codis are, rapid disintegration of the tablet in water with resulting greater ease of administration, and far less likelihood of intolerance by the patient. The chance of gastric irritation is minimised because there are no undissolved particles of aspirin.



COMPOSITION:
Each Codis tablet contains: Acid Acetylsalicyl. B.P. 4 grs., Phenacet. B.P. 4 grs., Codeine Phosph. B.P. 0.125 grs., Calc. Carb. B.P. 1.2 grs., Acid. Cit. B.P. (Exsic) 0.4 grs.

Codis is not advertised to the public

RECKITT & COLMAN (AFRICA) LTD., P.O. BOX 1097, CAPE TOWN

PHEVITAN

does
double
duty...



THE SEDATION IS IN THE SUGAR COATING

These tablets, consisting of our well known Petervite B Formula, plus Phenobarbitone, provide the benefits of the Vitamin B Complex supplementation as well as Phenobarbitone, which exerts the sedation required for patients complaining of nervousness, fatigue and anorexia. In PHEVITAN, we have departed from the normal method of manufacture by the inclusion of the Phenobarbitone in the sugar-coating. By this method of administering the sedation, the patient will receive immediate benefit and a feeling of euphoria

is the result. This is so vital in nervous patients.

The formula: Each tablet contains: Vitamin B₁, 2 Mgm.; Vitamin B₂, 1.5 Mgm.; Vitamin B₆, 0.25 Mgm.; Nicotinamide, 20 Mgm.; Calc. Pantothenate, 2.5 Mgm.; and Phenobarbitone, ½ Gr. The dosage: One tablet before meals and at bedtime. If desired, the bedtime dose may be increased to three tablets for several evenings until the daytime dosage has taken effect.

PHEVITAN TABLETS are supplied in: 40's, 100's and 500's. Price to the patient: 40's — 4/6, 100's — 9/6, 500's — 42/6.

Manufactured in South Africa by



Established 1842

P.O. Box 38
CAPE TOWN

113, Umbilo Road,
DURBAN

P.O. Box 2238
SALISBURY

P.O. Box 5785
JOHANNESBURG

South African Medical Journal

Suid-Afrikaanse Tydskrif vir Geneeskunde

VAN DIE REDAKSIE

SUIKERSIEKTE EN SWANGERSKAP

Stoornisse in die koolhidraatmetabolisme kan te eniger tyd gedurende swangerskap, maar vernameel gedurende die laaste ses maande, plaasvind. Suikersiekte, tydelik van aard, wat gedurende swangerskap en weer gedurende agtereenvolgende swangerskappe opdoem, kan blywend van aard word. Gedurende swangerskap word daar oënskynlik ekstra eise aan die eilande van Langerhans en aan insulienvervaardiging gestel; by families met 'n neiging tot suikersiekte, of by vrouens wat vir suikersiekte vatbaar is, is ontwigting van die koolhidraatmetabolisme bewysbaar baie jare voordat permanente klinies-erkenbare suikersiekte waarneembaar is.

Kliniese waarnemings het getoon dat ontwigting van die koolhidraatmetabolisme tydens swangerskap tot ernstige vrugverlies lei; verdere inligting behoort ingewin te word oor die rol wat 'n ontwigte koolhidraatmetabolisme speel in miskrame wat ongeveer die derde maand van swangerskap plaasvind. Sterftes in die baarmoeder, aan die einde van die swangerskap, of sterftes net na geboorte, kan meer geredelik met die moeder se vatbaarheid vir suikersiekte in verband gebring word. Hierdie kinders se ontwikkeling is gevorder, hul is oorgewig en hul gelaatstrekke bring Cushing se sindroom in gedagte. Korreksie van die ontwigte moeder-omgewing deur insulienbehandeling slaag daarin om hierdie suikersiekte-embriopatie te voorkom. 'n Buitengewone verantwoordelikheid rus op diegene wat verwagende moeders van advies bedien; hul moet besef dat dit belangrik is om gedurende swangerskap glukose-duldingstoetse onder sekere omstandighede uit te voer, d.w.s. as daar glikosurie is of as daar 'n familie-neiging tot suikersiekte bestaan of as die vrou se geskiedenis van miskrame, doodgeboorte of groot babetjies getuig, of as die vrou self meer as 4.5 kg. (10 lb.) by geboorte geweeg het.

Heelwat navorsings is gedoen oor die aanpassing van die pankreas-eilande by die funksionele las wat swangerskap op hul lê. Die formaat en getal van die eilande vergroot opvallend om sodoende hiperglisemiefaktore—o.a. ooraktiwiteit van die bynierskors—die hoof te bied. Gewoonlik is die pankreas-eilande in staat om te verhoed dat die bynierskors hormone bewysbare veranderinge in die bloedsuiker veroorsaak. Dit kom voor dat die verhoogde aanvraag na insulien gedurende

EDITORIAL

DIABETES AND PREGNANCY

Disturbances in carbohydrate metabolism may appear at any time during pregnancy but especially in the last two trimesters. Transitory diabetes occurring in a pregnancy and recurring in successive pregnancies tends to become permanent diabetes. During pregnancy additional demands are evidently made on the islets of Langerhans and the production of insulin; and in families with a diabetic trait, or in prediabetic women, the disordered carbohydrate metabolism will be demonstrable many years before permanent clinically recognizable diabetes becomes apparent.

Clinical observations have shown that serious foetal mortality results from the disordered carbohydrate metabolism in pregnancy; more information is desirable about the part played by disordered carbohydrate metabolism in connection with the miscarriages which occur about the third month of pregnancy. Intra-uterine deaths at the end of pregnancy and in the neonatal period have been more easily related to prediabetes in the mother. The children are advanced in development, over weight, and in facial appearance recall Cushing's syndrome. Correction of the disordered maternal environment by insulin is effective in preventing this diabetic embryopathy. A special responsibility rests on those who give prenatal advice; they should realize that it is important to make glucose-tolerance tests in the course of pregnancy in certain circumstances, viz. where glycosuria has been demonstrated or where there is a family tendency to diabetes, or when the woman gives a history of abortion, stillbirths or large babies, or if the woman herself is known to have weighed more than 4.5 kg. (10 lb.) at birth.

Much research has been done on the adaptation of the pancreatic islets to the functional burden imposed on them by gestation. A striking increase in the shape and number of the islets is found to develop in order to combat hyperglycaemic factors. Among these is the hypercorticism of pregnancy. Normally the capacity of the pancreatic islets prevents the cortical hormones from producing demonstrable changes in the blood sugar. Throughout pregnancy it appears that the

die volle swangerskaptidperk, waf deur die ooraktiwiteit van die bynierskors aangewakker word, die funksionele kapasiteit van die eilande swaar belaa. Die ooraktiwiteit van die bynierskors tydens swangerskap is meer regstreeks funksioneel met die eilande betrokke as die ander buislose klierfaktore; die betrokke rol wat die groeiormoon van die voorste harsingslymklier, die skildklierhormone, die estrogene hormone en die gonadotrophins speel, vereis ook verdere studie sodat 'n helderder beeld van buislose klierontwikkeling tydens swangerskap gevorm kan word. Swangerskap vereis 'n nuwe ewewig tussen die verskillende hormone.

Die pankreas wat aan oorgeërfde funksionele gebrek ly, word oorlaai en 'n besliste ontoereikende kan daarop volg. Alhoewel die ontoereikende eers tydelik is, sal dit as gevolg van die duur, herhaling en die hewigheid van die bynierskors-ooraktiwiteit tydens swangerskap uiteindelik permanent word.

Verslae deur Hoet¹ oor proefondervindelike navorsing met konyne i.v.m. suikersiekte en swangerskap het lig op die kliniese probleme gewerp. Vroeër bevindings dat herabsorbering van die vroegvrug in diere plaasvind wat eers gealloksaneer is, word bevestig. Die belangrikheid van glukokortikoidhormone (of corticotrophin) met die volhou van swangerskap en die regulering van vrugvoeding is gedemonstreer. Dit kom ook voor asof die vrugafdrywende uitwerking, wat sekere dosisse glukokortikoidhormone veroorsaak, met ernstige ontwrigting van die glukose-metabolisme gepaard gaan. Nie-vrugafdrywende dosisse verhoog die plasentalglikogeen en begunstig die toevoer van glikogeen na die fetus.

Die permanente suikersiekte van die 40-jarige vrou is die gevolg van 'n aantal skadelike faktore wat die eilande van Langerhans benadeel; ooreet en vetsug is nadelig. Vatbaarheid vir suikersiekte of 'n ontoereikende produksie van insulien is geneig om sigself te openbaar deur ontwrigting van die koolhidraatmetabolisme tydens swangerskap. Insulien-behandeling om tydelik hiperglisemie tydens swangerskap te bestry mag voorkom dat die moeder permanente suikersiekte ontwikkel en mag suikersiekte-embriopatie in die baba verhoed. Hierdie boeiende en praktiese kliniese probleme word meer volledig deur Hoet¹ beskrywe.

1. Hoet, J. P. (1954): *Diabetes*, 3, 1.

increased need for insulin stimulated by the hypercorticism puts a strain on the functional capacity of the islets. Among the various endocrine factors the hypercorticism of pregnancy is most directly in functional relation with the islets; the parts played by the growth hormone of the anterior pituitary gland, the thyroid hormone, oestrogens and gonadotrophins also requires further study in order that the endocrine disorders of pregnancy may be integrated into a more complete picture. The various hormones need to establish a new equilibrium during pregnancy.

The pancreas which has an hereditary functional deficiency is subjected to stressful circumstances which can lead to definite insufficiency; and though the insufficiency is temporary at first, the duration, repetition and intensity of the periods of hypercorticism during pregnancy will ultimately bring the pancreas to permanent insufficiency.

Experimental studies on diabetes and pregnancy in rabbits reported by Hoet¹ have shed light on the clinical problems. Confirmation was obtained of earlier work which showed that in the previously alloxanized animal premature resorption of fetuses occurs. The important role of glucocorticoids (or corticotrophin) in maintaining gestation and in regulating foetal nutrition was demonstrated. Moreover the abortive action which glucocorticoids may exercise in certain doses appeared to be accompanied by serious disorder of glucose metabolism. In non-abortive doses the glucocorticoids increase placental glycogen and favour the passage of glucose to the foetus.

The permanent diabetes which appears in women in the fourth decade results from numerous harmful influences that have damaged the islets of Langerhans; in this regard overeating and obesity have an unfavourable effect. The diabetic trait, or weakness of insulin-production, tends to manifest itself as disturbance in carbohydrate metabolism in the course of pregnancy. The correction of temporary hyperglycaemia in pregnancy by insulin may prevent the development of permanent diabetes in the mother and diabetic embryopathy in the infant. Fuller details of these fascinating and important practical clinical problems are presented by Hoet¹.

1. Hoet, J. P. (1954): *Diabetes*, 3, 1.

THE PRACTITIONER IN THE BRITISH NATIONAL HEALTH SERVICE

In a comprehensive description of *Health Services in Britain*, published by the Central Office of Information, London,¹ there are some interesting details concerning the Practitioner Service, which comprises general-practitioner, dental, ophthalmic and pharmaceutical services.

The Service is the present outcome of the general-practitioner service inaugurated in 1911 and was constituted under the National Health Service Act 1946, which aimed at promoting 'the establishment of a

comprehensive health service, designed to secure improvement in the physical and mental health of the people, and the prevention, diagnosis and treatment of illness'. By this Act the Minister of Health was made responsible to parliament that health services of every kind were available to everyone who needed them. What some people had previously received as a form of charity was at last to be recognized as the birthright of every citizen in the United Kingdom.

Essential freedoms have been safeguarded. The public is free to use the Service, or any part of it, as it pleases. The patient is free to choose and to change his doctor. The Service doctor also has a similar freedom to accept

1. R.F.P. 2796 (1954): Reference Division, Central Office of Information, London.

or refuse patients as he wishes, nor does enrolment in the Service preclude him from attending patients who have not joined the Service. He is free from interference in his clinical judgment; he can treat in whatever fashion he pleases, and can call in a consultant or transfer a case to hospital without undue formality. There is, however, one respect in which he is restrained, viz., in choosing the locality where he shall practise; he is required to obtain the approval of a coordinating (Medical Practitioners') committee, whose function is to maintain an even distribution of practitioners throughout the country.

The doctor in the Service is remunerated by a capitation payment of 17s. a year for each patient registered with him, with an addition of 10s. for every patient within the range of 501 to 1,500 on his list. Annual remuneration can therefore vary from £425 for a list of 500 patients to £3,475 for a list of 3,500. (The present maximum number of patients allowed on one principal's list is 3,500; the actual average number is 2,400.) In addition, this income may be augmented by mileage payments and by inducement payments (for practising

in uncongenial areas), administering anaesthetics, home dispensing, etc.

There are some 22,000 general practitioners in the Service (about 600 remaining outside), and also 11,000 dentists, 1,000 ophthalmic practitioners, 7,000 opticians and 16,000 chemists. Ninety-five per cent of the 50 million population of the United Kingdom is using the Service.

While the dental, ophthalmic and pharmaceutical services are free, it has been found expedient to charge a fee for the articles they supply. Thus spectacles cost 10s. a lens plus the cost of the frames (a total of 25s.-43s.); doctor's prescriptions are dispensed at a nominal charge of 1s. per form; and for dentures and some other dental services certain charges are made.

The cost of the medical (other than hospital and specialist), pharmaceutical, dental and ophthalmic services in the financial year 1952-53 was £160 million, out of a total expenditure on the National Health Service of £526 million. These figures are for the whole of the United Kingdom.

ARTERIOGRAPHY AND AORTOGRAPHY IN PERIPHERAL VASCULAR DISEASE

M. A. LAUTRÉ, F.R.C.S. (ENG.)

Johannesburg

The treatment of occlusive vascular disease has hitherto been on the whole unsatisfactory and of limited scope. Systemic vasodilators, despite elaborate claims made for them by the manufacturers, do not produce dramatic results and it is doubtful whether their prolonged exhibition has any lasting effect in dosages which are free from side effects. Surgical vasodilatation by removing the vasoconstrictor nerve-supply to a part has been really the only means at our disposal of ameliorating the symptoms of this disease. Although extremely valuable over a wide range of conditions its scope nevertheless remains limited. We must accept the fact that this procedure affects mainly the small artery bed and is only of value if the stream that feeds this bed is adequate. It yet remains to be proved that sympathectomy increases the lumen of the large arteries; and the extent to which intermittent claudication is relieved by such denervation always remains an unpredictable quantity. The essential problem therefore remains primarily that of dealing with the stream and secondly that of controlling its terminal distribution.

The one great step forward in the study of occlusive vascular disease has been X-ray visualization of the arterial tree after injection of an opaque dye. Although initiated by Das Santos as far back as 1929 it is only within the last decade that the procedure has become generally applied, and a wide field in the diagnosis and treatment of this disease thus opened out. Arteriography of the leg vessels by means of percutaneous puncture of the femoral artery at the inguinal ligament has been widely practised. This procedure, however, is sometimes

quite difficult; it has moreover this disadvantage that the information obtained is limited to a portion of one limb in a disease which it is known may affect any part of the arterial tree. Much more information can therefore be obtained by injecting the dye directly into the aorta and, by means of serial X-rays, obtaining views of the whole arterial supply of both lower extremities at the same time.

TECHNIQUE

The patient is placed in a prone position on the X-ray table under general anaesthesia—intubation being advisable. Sensitivity to the dye should have been previously checked. The needle (a 25-cm., 16-18 gauge) is entered on the left side below the 12th rib, much as in the position for a lumbar block; it is then allowed to slide over the vertebral body until it enters the aorta. After barbotage to ensure that the point is adequately within the lumen, a syringe containing the dye (75% Pyelosil) is attached by means of a polythene tube with securely-fitted adaptors. The injection is then made as rapidly as possible and the X-rays taken just before the plunger reaches the bottom of the syringe. Where a view is required of the abdominal aorta and its visceral branches only, the problem is easy as 10-15 c.c. of dye are adequate. In visualization of the leg vessels, however, large amounts up to 40 c.c., are necessary, and it becomes difficult to inject the dye fast enough to prevent its excessive dilution in the blood stream—the injection should not occupy more than 4 seconds. Various mechanical pumps have been devised for this purpose

but I find that with a well-fitted 50-c.c. Leurlock syringe and a certain amount of grim determination the injection can usually be accomplished within this period.

Serial X-rays down the leg are then taken at 5-, 10-, 15- and 20-second intervals. With a mechanical cassette changer this presents no difficulty, but if this is not available good pictures can still be obtained, depending upon the ingenuity of the radiologist and good teamwork. It is essential that as many serial pictures as possible be taken over a period of at least 20 seconds from the moment of initiating the injection. In a young healthy subject, for example, the dye may have gone past the femoral arteries at 10 seconds, whereas in an elderly subject with occlusion the medium, after circulating lazily through the collaterals, may only show up in the lower femoral or popliteal as late as 20 seconds.

SURGICAL APPLICATION

Occlusive vascular disease is in the main a systemic and progressive malady, for which we know no cure. Nevertheless its manifestation may be so localized and its progress so gradual that surgical intervention on isolated sectors of the arterial tree appears to be a rational procedure.

Firstly, there is the question of thrombendarterectomy. This procedure, which is essentially a filleting or reaming-out process applied to the obstructed segments of the artery, has been fairly extensively tried out. It carries with it naturally the risk of thrombosis of the raw segment (despite heparinization), and the weakening of the vessel wall introduces the possibility of a dissecting aneurysm.

Reviewing the literature on this subject up to date one feels that this procedure has a definite place in dealing with short areas of narrowing or obstruction of the large vessels, where the blood flow is rapid enough to prevent coagulation.

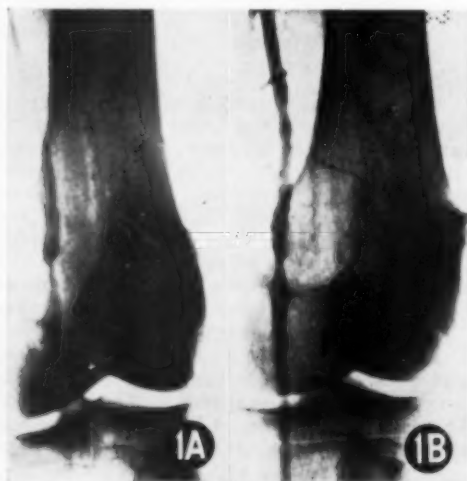


Fig. 1. A and B. Pre- and post-operative radiographs of a localized area of obliterative disease. The operation (endarterectomy) gave immediate relief to the severe claudication and rest pain.

Much more appealing is the idea of resection of an obstructed or narrowed segment with restoration of the continuity of the vessel. Much work has been done in this field and all manner of substitutes for the resected segment employed—tubes of Vitallum plastic, nylon mesh, fascial envelopes and arterial and venous grafts. The consensus of opinion at present appears to be that the only really satisfactory replacement-material is an arterial graft taken directly from a cadaver or from an arterial bank.

Apart from these major applications a wider field for arteriography is gradually opening out.

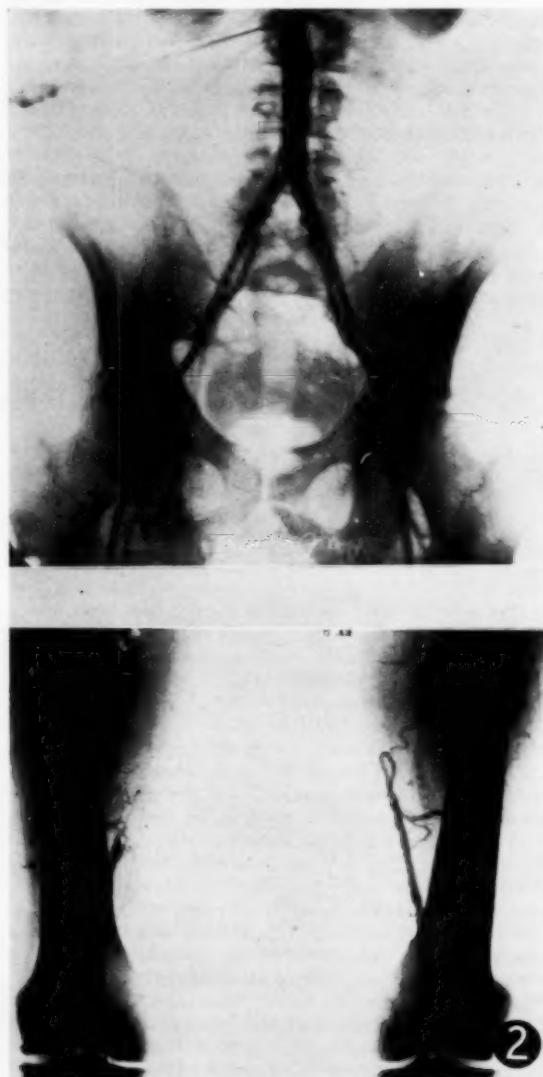


Fig. 2. Aorto-arteriogram showing complete occlusion of both femoral arteries, in a patient with severe claudication. Grafting is to be carried out.

ANEURYSM AND ARTERIO-VEINUS FISTULA

In the treatment of these conditions, whether congenital or acquired, the main difficulties confronting the surgeon are (a) to determine the extent of the collateral circulation, (b) to determine the state of the vessel walls and (c) the occurrence excessive bleeding during operation. An exact picture of the shape and size of the aneurysm or fistula, the state of its wall, and the location of the collaterals, is an immense help in the planning and execution of the operation and may indeed be the main factor in the preservation of a limb.

In arterio-venous fistula an exact knowledge of the site of the shunt—notoriously difficult to diagnose clinically—may enable the surgeon to go straight to the focal point and carry out reconstructive surgery rather than quadruple ligation. Blood loss, sometimes an extremely serious consideration can be thus limited and the operative time reduced even perhaps to the extent of enabling the operation to be carried out in a bloodless field.

Furthermore, treatment of skeletal hypertrophy due to congenital arterio-venous shunts is now by means of careful arteriography coming within the realms of practical possibility.

EMBOLISM

Although the diagnosis and approximate position of an embolus can usually be determined clinically, cases occur from time to time in which the differential diagnosis between this form of vascular obstruction and the sudden occurrence of thrombosis in a previously diseased vessel becomes a matter of some difficulty. In such, admittedly rare, instances (provided the patient is in a fit condition to stand the procedure) arteriography may be the only deciding point in the election of conservative or operative treatment. Moreover, visualization of the state of the general arterial tree and the extent of the collateral circulation may prove essential factors in this somewhat difficult decision.

ANGEIOSPASM

Although theoretically contra-indicated as a possible aggravating factor, arteriography has nevertheless been successfully used in the diagnosis of angeiospasm. This applies particularly to the sudden onset of acute regional arterial spasm of reflex origin—e.g. caerulea dolens. Sympathetic block in such conditions has proved to be of little value, and it is possible that early exploration and the topical use of papaverine, as suggested by Kinmonth, may be a critical factor in the prevention of gangrene—a sequela by no means unknown in such conditions of extreme reflex arterial spasm.



Fig. 3, A and B. Pre- and post-operative radiographs of an arterio-venous fistula in Hunter's canal, showing restoration of the artery.

SURGICAL TREATMENT OF A CASE OF WRY-NECK

JACK PENN, F.R.C.S.

Brenthurst Clinic, Johannesburg

and

WILFRED KARK, F.R.C.S.

Department of Surgery, University of the Witwatersrand, Johannesburg

M.L., a European girl aged 13 years, was referred to us for treatment on 18 December 1950. Although her torticollis (Fig. 1) was associated with marked scoliosis and asymmetry of the face, her parents had not noticed any deformity until it was pointed out to them by their family doctor.

X-ray examination revealed 'considerable tilting of the 2nd cervical body on the 3rd, so that the dens of the second is directed upwards and to the right'; the skull and facial bones were out of normal alignment, with secondary alteration of the bony architecture of the maxillary sinus, the nasal cavity and the mandible on the one side. Although these features of an established wry-neck were present, together with commencing hemiatrophy of the face,

it was nevertheless decided to remove the involved right sternomastoid muscle.

A Z-incision was made exposing the fibrosed muscle, and the sternal and clavicular portions were removed in their lower four-fifths; fibrous tissue replacement was particularly marked near their lower attachment. The thickened and contracted carotid sheath was also excised from the level of the clavicle to just below that of the mastoid bone. The patient's head immediately released itself into an almost normal position. The wound was closed and drains were inserted. No splintage was utilized and the patient was instructed to carry out graduated exercises of the neck from the fifth day after operation.



Twenty months later (28 August 1952) all asymmetry of the face had corrected itself (Fig. 2). Scoliosis was not evident and the patient enjoyed full movement of the head. X-ray studies showed that 'the asymmetry of the vault of the skull previously demonstrated has become less marked. It can still be detected in increased convexity of the right half of the vault as seen in the sagittal projection, and in the decreased size of the left maxillary sinus, the left nasal cavity and the left half of the mandible. These changes, however, are all less marked than at the previous examination some 2 years ago'. And further that 'the alignment of the cervical vertebrae has returned practically to normal . . . the tilting of the 2nd cervical vertebra on the 3rd, previously demonstrated, has now been entirely corrected and alignment here is normal'.

The patient's only complaint at this time was sensitiveness to the hollowness on the right side of her neck, and the prominence of the medial end of the clavicle following the removal of the right sterno-mastoid muscle. Therefore on 29 August 1952 a large spindle-shaped mass of derma-fat was removed from the right buttock after shaving off the epithelium. This graft was placed in



the position normally occupied by the right sterno-mastoid muscle, the lower end being carefully wrapped round the medial end of the clavicle, which was very prominent. In order to allow for contraction the graft inserted was twice the amount required to produce a normal contour (Fig. 3). This reduced itself to normal shape within 4 months and all evidence of wry-neck has now

disappeared (Fig. 4). Slight keloid formation of the lower end of the scar is still present.

DISCUSSION

The operation of excision of the sterno-mastoid muscle for muscular torticollis was first advocated by Mikulicz in 1895.¹ Although the operation is not universally accepted as the most satisfactory one, many adherents testify to its value and claim its superiority over other forms of treatment. Many workers²⁻⁵ have used the operation over representative series of cases and are enthusiastic advocates of its efficacy. Their practice and general recommendation is to perform the operation in early infancy as soon as the diagnosis of muscular wry-neck is beyond doubt.

The case reported here demonstrates that considerable improvement may be achieved by the operation even at a later age. Not only were the deformities of marked cervical scoliosis and tilting of the head entirely eliminated, but there was also noticeable improvement in the secondary bony changes and facial atrophy that had supervened.

The cosmetic defect consisting of a marked hollow in the neck and prominence of the sternal end of the clavicle does not feature in the literature. In the case now reported it was very marked; so much so that one practitioner had tentatively diagnosed a dislocation of the inner end of the clavicle. The derma-fat graft proved effective in masking the deformity which might otherwise have negated much of the benefit of the operation.

SUMMARY

Excision of the sterno-mastoid muscle was performed for muscular torticollis in a girl of 13 years of age. The scoliosis and tilt of the head were corrected by the operation and there was also improvement in the secondary bony changes and facial atrophy.

A derma-fat graft was used to fill out the hollow left by the operation.

Author's Note. Other cases of a similar nature, particularly one in an adult aged 27 years, have come to our notice since 1950; considerable improvement has resulted from the operation.

We are grateful to Dr. M. H. Feinsinger for the X-ray studies on this case; the quotations in this paper are extracts from his reports.

REFERENCES

1. Mikulicz, J. (1895): *Zbl. Chir.*, **22**, 1.
2. Chandler, F. A. and Altenberg, G. (1944): *J. Amer. Med. Assoc.*, **125**, 76.
3. Chandler, F. A. (1948): *J. Bone Jt. Surg.*, **30A**, 566.
4. Brown, J. B., McDowell, F. and Fryer, M. P. (1950): *Plast. Reconstr. Surg.*, **5**, 301.
5. Breckenridge, R. L. (1951): *Arch. Surg.*, **62**, 134.

DIE SUID-AFRIKAANSE GENEESKUNDIGE EN TANDHEELKUNDIGE RAAD

VERSLAG VAN ONDERSOEK NA DIE GEDRAG VAN DR. N.K.

Die Geneeskundige Raad het op sy jongste vergadering 'n verslag van die Uitvoerende Komitee van die Raad oorweeg in verband met 'n ondersoek wat genoemde Komitee na die gedrag van Dr. K. gehou het op sy vergadering in April 1954.

Dr. K. was beskuldig van die volgende oortreding:

Dat hy, 'n geregistreerde geneesheer, skuldig is aan onbetaamlike gedrag of skandeleke gedrag of aan gedrag wat, met die oog op sy professie, onbetaamlik of skandelek is,

deurdat hy in die Hooggeregshof van Suidwes-Afrika op 10 September 1953 skuldig bevind is aan die misdaad van kriminele vrugafdrywing.

Die Geneeskundige Raad het na oorweging van die verslag oor die ondersoek en 'n volle afskrif van al die getuienis wat by die ondersoek afgelê is, Dr. K. skuldig gevind van skandeleke gedrag en die Raad het besluit dat sy naam van die register van geneeshere in Suid-Afrika geskrap word.



FOCUS ON

Gastro-Enteritis

The need for a modern method of controlling many of the distressing infections of the gastro-intestinal tract is met by the introduction of Guanimycin.

Guanimycin is the first South African oral preparation of streptomycin combined with sulphaguanidine.

Guanimycin is issued as a stable dry powder from which a smooth, palatable, homogeneous suspension may be made by simple mixture with water.

Guanimycin is indicated for the treatment of gastro-enteritis, bacillary dysentery, summer diarrhoea, and other mixed infections of the gastro-intestinal tract in infants, children and adults.

GUANIMYCIN

Trade Mark

ORAL STREPTOMYCIN SULPHATE with SULPHAGUANIDINE

In bottles to prepare 4 fluid ounces.

Literature on application.

ALLEN & HANBURY'S (AFRICA) LTD.
INCORPORATED IN ENGLAND
121 CONGELLA ROAD • DURBAN



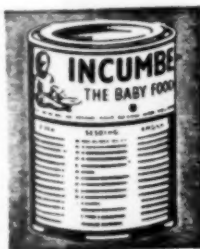
New Protein Incumbe

*Contains specially prepared, de-fatted milk powder
— gives the Non-European infant an equal chance
of health from the beginning.*

By increasing the protein content of Incumbe to 22.8% and adding carbohydrate, fat-ratio-compensation has been effected and New Protein Incumbe, when used in accordance with the feeding tables, offers a food comparable in nutritional value with cows' or dried milk.

25% of the whole food calories are protein, this again giving a ratio of 45% milk protein and 55% mixed cereal protein.

New Protein Incumbe, being a mixed cereal, allows for a much better distribution of essential amino-acids than does one type of cereal only. Incumbe contains Soya Bean Flour, Wheat, Maize, and Kaffir Corn — this last being especially valuable owing to its nicotinic acid content, the Pellagra-Preventing Factor.



Feeding Tables are calculated on the Mothercraft system of calorie estimation.
Calories values are:

103 Calories per ounce of Incumbe.
11 Teaspoons = 1 oz.
9.4 calories = 1 level teaspoon.

INCUMBE BABY FOOD

Feeding tables are available in all Native dialects. For a supply of these write, Dept. 851, Free Advice Bureau, Hind Bros. & Co. Ltd., Umbilo, Natal.

Please Support Our Advertisers — Ondersteun Asseblief Ons Adverteerders



PACYL

For HYPERTENSION

- ¶ **PACYL**, a Choline derivative, acts on the parasympathetic system in a physiological manner, producing a lasting reduction in cases of pathologically raised blood pressure.
- ¶ **PACYL** has exceptional merits in relieving the distressing subjective symptoms, such as headache, vertigo, insomnia, etc.
- ¶ **PACYL** has also proved to be the treatment of choice for ambulant patients. No initial rest in bed is required and patients remain at work throughout the treatment.
- ¶ **PACYL** has a gentle and persistent vasodilator effect and removes local vascular spasm, thereby facilitating and improving the general circulation.
- ¶ **PACYL** has no side effects and there are no contraindications to its use.

Bottles of 50 and 200 tablets

For further information and samples apply to our Agents:
LENNON LIMITED, P.O. Box 8389, JOHANNESBURG

VERITAS DRUG COMPANY LIMITED

LONDON AND SHREWSBURY, ENGLAND



For smooth gentle control of constipation

Agarol*, an emulsion of mineral oil and agar-agar with phenolphthalein, provides a treatment designed to re-establish the correct pattern where bowel evacuation is deranged. The phenolphthalein in Agarol provides gentle threshold stimulation; the hydrophilic properties ensure a moist yet well formed stool; the agar-agar content supplements mucin deficiency; the highly emulsified mineral oil mixes readily with the intestinal contents to form a soft lubricated mass. The palatability of Agarol makes it acceptable to the most fastidious patient.

INDICATIONS For chronic constipation and intestinal auto-intoxication. For restoring sluggish bowel activity to normal regularity in the elderly. For expectant or nursing mothers. To obviate straining in patients with high blood pressure, tuberculosis or heart disease. To provide lubrication where hemorrhoids or other painful anal conditions are present.

NO WARNER PREPARATION HAS EVER BEEN ADVERTISED TO THE PUBLIC

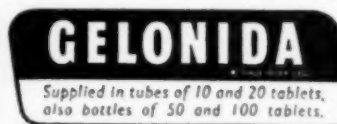
WM. R. WARNER & COMPANY (PTY) LTD., 6-10 Searle Street, Capetown.



SEDATION IN DYSMENORRHOEA

Dysmenorrhoea is a symptom or entity in which Gelonida* provides prompt and effective relief not only of pain but also of the associated mental distress. The anxiety and irritability so characteristic of genital disturbances is particularly evident in dysmenorrhoea.

Gelonida is both analgesic and sedative and may be confidently prescribed in the treatment of pain and anxiety in menstrual distress.



Distributors: CHAMBERLAIN'S (PTY) LTD., 6-10 Searle Street, Capetown.
Successors to: William R. Warner & Co. Ltd., Power Road, London.

REVISION SERIES

III. THE MANAGEMENT OF VARICOSE VEINS

D. J. DU PLESSIS, M.Ch.(RAND), F.R.C.S.(ENG.)

Department of Surgery, University of Cape Town

The results of the former conventional treatment of varicose veins were disappointing, but with better understanding of the basic pathology of this condition, they have greatly improved in recent years.

In the management of varicose veins the first decision to be made is whether the varicosities are primary or secondary.

PRIMARY VARICOSE VEINS

This name is given to varicosities where the primary defect exists in the veins of the superficial venous system. The diagnosis can only be made by careful exclusion of the various causes of secondary varicose veins. The common types of secondary varicose veins which must be looked for in all cases are due to:

1. Mechanical obstruction of the veins draining the leg.
2. An arterio-venous fistula in the vicinity.
3. Pregnancy.
4. Incompetence of the deep venous system.

After it has been decided that the varicose veins are primary, it is important to establish whether the symptoms complained of are produced by the varicosities. Frequently some other disorder of the leg exists and produces symptoms which are wrongly ascribed to the very obvious varicose veins after only a cursory examination. It is thus imperative to make a careful examination of the legs and feet and it is a wise clinician who makes a routine inspection for arterial insufficiency in all patients complaining of symptoms in the legs.

Once it is clear that the varicosities are primary and that they are responsible for the symptoms, treatment can be recommended. In a certain proportion of cases no surgical treatment is advisable; this applies particularly to very old and feeble patients and people with minimal symptoms or even none. Before this decision is taken the practitioner must keep in mind the possibility of complications, viz. haemorrhage, thrombosis and infection. The incidence of these can be lessened by the use of well-fitting elastic stockings whenever the patient is erect (to keep the veins compressed) and regular exercise and massage of the limb (to encourage the venous drainage). Good muscular function is an important factor in the venous drainage of the leg and should always be encouraged, whatever form of treatment is recommended.

The decision to advise surgical treatment should automatically imply that an operation is required. The injection treatment of varicose veins is not recommended; it produces thrombosis of the veins but this thrombus eventually recanalizes, resulting in a recurrence of the varicosities. In addition, allergic manifestations of varying degrees of severity have been reported and local sloughing may occur if there is any subcutaneous

extravasation of the fluid used. A much graver complication, however, is that the sclerosant may produce deep-vein thrombosis, which leads to disabling consequences; none of the methods of injection can completely avoid this dreadful complication, and therefore injection treatment should not be used.

In deciding on the type of operation to perform, the anatomy, physiology and pathogenesis of the condition must be fully considered.

The venous drainage of the leg takes place along two systems of veins—the superficial and the deep. It is customary to think of the superficial veins as the long and short saphenous veins only, but this concept is wrong, and is the cause of many disappointments in treatment. The superficial veins are to be looked upon as a diffuse system of veins, of which two are sufficiently large and constant to warrant specific names. This superficial system of veins drains into the deep system by means of numerous communicating veins supplied with valves which allow blood to flow in one direction only, viz. from the superficial system to the deep.

The best-known communicating veins are at the terminations of the short and long saphenous veins where they pierce the deep fascia to drain into the popliteal and femoral veins respectively. These communications are large, constant and direct and are thus readily distinguished clinically and at operation. There are, however, many other communicating veins in relation to the intermuscular septa on the medial, lateral and posterior aspects of the leg and the medial side of the thigh. These communications are small and relatively inconstant in position and they may be indirect; this means that, although some directly link a main superficial vein with the deep system, many do so indirectly by means of intermediate smaller superficial veins. It is important to keep this in mind, because if only the junctions with the main veins are obliterated, the communications with the small superficial veins are left patent and will produce recurrences.

Primary varicose veins arise because of incompetence, congenital or acquired, of one or more of these communicating veins. This allows blood to flow from the deep to the superficial veins, which lie unsupported in the loose subcutaneous tissues and will consequently dilate readily. The commonest communicators to be thus affected are those at the terminations of the long and short saphenous veins, and for practical purposes it is wise to assume incompetence of these terminal communications in all cases of varicosity of the relative vein. This means that a varicose long saphenous vein indicates an incompetent sapheno-femoral communication, and a varicose short saphenous vein an incompetent sapheno-popliteal communication. But it must be kept in mind that other communicators may also be incompetent.

TREATMENT

Operative treatment must obviously have two distinct objectives. The dilated veins must be removed and all the incompetent communicators must be obliterated.

The former is easily achieved. The vein in the thigh can be stripped, using one or other type of vein stripper. This may also be possible below the knee but if the vein is very tortuous the stripper cannot be passed along the vein and in that case it should be excised through a few small incisions made along its course. Haemorrhage is readily controlled by tilting the table and by firm compression.

It is difficult to satisfy the other aim of surgical treatment, namely obliteration of the incompetent communicators, mainly because they are clinically so difficult to locate. As has been said, it is wise to assume incompetence of the sapheno-femoral junction in all cases affecting the long saphenous vein and it must thus be ligated in all such cases. Because of the numerous and inconstant branches joining the long saphenous vein in this region, the upper two inches of the vein should be excised and ligated with a transfixing ligature, flush with the femoral vein. If the short saphenous vein is involved, a similar operation is performed at its upper end in the popliteal fossa but it is usually adequate to ligate the vein as it pierces the deep fascia.

This operation alone will only cure about half the patients. The others have additional incompetent communications in the leg or thigh and mere stripping (or ligations) of the main vein will not obliterate the intermediate small superficial varicose veins. Obviously the incompetent communicating veins must be cut and ligated where they pierce the deep fascia, and to be able to do this the surgeon must know where these veins occur and how to determine that they are incompetent.

As already mentioned, these communicating veins may be found at practically any of the intermuscular septa, but those most frequently affected are 5 or 6 veins emerging in a vertical row along the medial aspect of the leg 1-2 cms. posterior to the medial border of the tibia. One or more of these are incompetent in over 80% of cases. The next most commonly affected group are those emerging between the gastrocnemius and peroneal muscles on the lateral aspect of the leg. In the thigh there are only two incompetent communicators seen with any frequency; they both pierce the deep fascia close to the long saphenous vein, one about mid-thigh and the other just above the knee.

It may be difficult to recognize clinically when these communicating veins are incompetent. Large bulbous dilations ('blow-outs') and large palpable defects in the deep fascia strongly suggest the presence of incompetent communicators, but this is by no means invariably correct. The best test is the 'two-finger test'. Segments of the varicose veins are emptied and obliterated above and below with the fingers; then if such an isolated segment fills it suggests that it is fed by an incompetent communicator. This test alone is unreliable, because if the communication is small and tortuous, filling is too slow to notice; and in any case it merely indicates the junction of the communicator with the varicose vein and not the site where it must be ligated.

Using these 3 methods all the suspected sites should be marked before the operation, and they should be carefully explored through adequate incisions. The communicators must naturally be cut and ligated as they pierce the deep fascia.

After the operation early ambulation is essential to prevent thrombosis of the deep veins.

Although this is the best operative procedure, recurrences commonly occur, either because an incompetent communicator has been missed or because other communicators have later become incompetent. It is thus wise to warn the patient to report back at the first sign of a recurrence, because it is then a minor procedure to ligate the responsible communicating vein and excise the distended superficial vein. Repeated small operations of this type may be required to keep the legs free of varicose veins.

SECONDARY VARICOSE VEINS

Consideration must now be given to secondary varicose veins resulting from the 4 conditions already enumerated.

1. MECHANICAL VENOUS OBSTRUCTION

This is an obvious cause of distended leg veins if the obstruction is in the groin but it may be missed if it is in the pelvis. A rectal and abdominal examination should therefore be performed in every case to exclude the latter condition. Treatment is obviously directed at the obstructing agent.

2. ARTERIO-VENOUS FISTULA

The short-circuiting of blood into the regional veins will produce marked varicosities. The diagnosis is easy if it is looked for and the treatment is that for the fistula.

3. PREGNANCY

Although compression of the pelvic veins by the enlarged uterus is probably partly responsible for varicose veins during late pregnancy, hormonal influences also play an important role and varicose veins may thus appear very early in pregnancy. The varicosities are usually widespread and often involve the vulva, thus producing quite a different appearance from primary varicose veins.

Pregnancy must be excluded before treatment is contemplated, because in this condition surgical treatment has unsatisfactory results. An elastic stocking (extending up to the groin if necessary) should be worn constantly and the usual physiotherapeutic measures must be practised. After delivery this regime must be continued and resolution may occur. If varicosities persist, they must be treated surgically as if they were primary varicose veins.

4. VARICOSE VEINS FOLLOWING DEEP-VEIN INCOMPETENCE

The valves in the deep veins may be congenitally absent or incompetent, or they may be rendered incompetent by the recanalization following on phlebothrombosis. The resultant deep-vein incompetence produces tremendous tension in the deep venous system in the erect position, as the valves are unable to break up the column

of blood into small segments. The veins are thus subjected to the pressure of a column of blood far greater than normal and this produces pain, relieved by elevating the limb. Any significant pain associated with varicose veins should warn the clinician of the probability of deep-vein incompetence.

This increased pressure is naturally transmitted to the valves in the communicating veins. These eventually give way, allowing the blood to flow into the superficial venous system under abnormally high pressure. When this occurs two distinct clinical pictures may be produced.

In the one variety, only the intermediate superficial veins are affected, resulting in oedema, cyanosis and persistent indolent ulceration in the vicinity of the incompetent communicating veins. The presence of one or more of these signs should thus indicate to the clinician that deep-vein incompetence exists. In the majority of cases the ulcer occurs above the medial malleolus but it may be above the lateral malleolus or on the back of the leg, depending on which communicators are affected. The oedema, ulceration and subsequent fibrosis will disguise clinical evidence of the underlying communicators and the unwary clinician may thus miss the cause of the ulceration. Note that in this type of case there is no varicosity of the main superficial veins.

In the other type of case the communicators drain effectively into both the intermediate and main superficial veins. This latter vein will dilate to accommodate the increased volume of blood and so in addition to the features mentioned above, there will now be varicosity of a main superficial vein. Its valves are initially normal and blood will therefore flow upwards in the normal direction, thus assisting the venous drainage of the limb. Sooner or later, however, the valves become incompetent under this strain and now blood will flow downwards, thus further interfering with the venous return.

In the management of this condition it must be kept in mind that the deep veins are permanently incompetent and that the communicating veins will thus be permanently subjected to abnormal pressures tending to render them incompetent. This is therefore a disease which cannot be cured. Surgical treatment is only palliative and must be followed by good and continuous supportive treatment for the rest of the patient's life.

Treatment of this condition consists of:

(a) Treatment of the Ulcer

This can almost always be healed by rest in bed. Elaborate local applications must be avoided since a dermatitis is very likely to develop. Regular sterile dressings and, if necessary, an appropriate systemic (never local) anti-bacterial agent will suffice.

If bed rest is economically impossible a similar effect can be obtained by compression bandages, left on for long periods to avoid the trauma of frequent dressings. 'Viscopaste' bandages from the base of the toes to the tibial tubercle, with only plain dry sterile gauze on the ulcer, are most effective and can be left on for 2-4 weeks, depending on the condition of the bandages. These bandages must only be applied once the oedema has subsided and after prolonged elevation of the limb and they must be continued until healing has taken place.

During this time activity must be reduced to a minimum.

In late neglected cases the ulcer may be so large that healing cannot occur spontaneously and then excision down to normal tissue followed by skin grafting will be required. The sepsis, however, must first be controlled.

(b) Treatment of the Superficial Varicose Veins

If the venous drainage in the main vein is upward, then it must obviously not be ligated, for fear of aggravating the venous congestion in the limb. If, however, it drains downwards, then it must be treated surgically in exactly the same way as primary varicose veins. As the ulcer forms in the vicinity of the most severely incompetent communicating veins, it is essential to explore the known sites of the communicators through generous incisions in the vicinity of the ulcer, even in the absence of clinically apparent varicosities.

This operation is usually only performed once the ulcer has healed, to avoid any possibility of sepsis. If the ulcer does not heal spontaneously, excision and skin grafting of the ulcer is performed at the same time as this operation, with due precautions to minimize the risk of sepsis.

(c) Subsequent Regime

The patients must be made to realise that constant care will be necessary for the duration of their lives. This must include:

1. Physiotherapy, as mentioned before. If there is fixation of the ankle joint, manipulation or even lengthening of the Achilles tendon will be required to ensure good functioning of the calf muscles.
2. As much rest as possible with the leg elevated. This may require an alteration in occupation and recreation.
3. Constant wearing of a well-fitting elastic stocking.
4. Great care to avoid trauma to the limb.
5. Scrupulous cleanliness of the limb (this includes avoidance of fungal infections of the feet).
6. Immediate treatment of even the smallest ulcer on the leg.
7. Further surgery to the superficial veins, should this become necessary.
8. Control of obesity, which lowers local vitality and possibly increases the back pressure on the incompetent veins by raising intra-abdominal tension.

(d) Treatment of the Deep Veins

The formerly popular operation of ligation of the femoral or popliteal vein has very poor results indeed and should never be performed for oedema or ulceration alone; neither of these are significantly improved by this operation. Deep-vein ligation should be reserved for those cases which, in spite of the treatment described above, still have persistent and disabling pain. In those cases it is better to ligate the superficial femoral vein than the popliteal vein, because a more adequate collateral circulation exists in the thigh and consequently there is less chance of making the condition worse. But it should be kept in mind that the results of this operation are disappointing and it should only be performed under exceptional circumstances.

MEDICINE IN THE CAPE IN THE EARLY DAYS OF THE CENTURY

A SIMPSON WELLS, M.B. (CAPE TOWN), M.A., M.D. (GLAS.) F.R.C.S. (EDIN.)

Cape Town

As many changes have taken place in the medical world, changes mostly for the better, it has occurred to me that it might be of interest to record some of the facts relating to our profession in the Cape during the early years of the century.

In 1901 I was released from military service as a 'civil surgeon' to do plague duty under the Cape Colonial Government in Cape Town, and I have known the Mother City since that date.

Of all the changes which have occurred during the years, none are more remarkable than the increase in the number of medical men. A comparison of the numbers of practitioners in the past with the present strength of the medical fraternity may serve as an introduction to this sketch.

In a paper presented in 1912 by our grand old man of medicine, Dr. C. F. K. Murray, it was recorded that in 1870 there were only 60 doctors in the Cape Colony, of whom 15 were in Cape Town and its suburbs. At the end of 1903 the Medical Register showed the total number of doctors in Cape Town and suburbs as 155. None of them were registered as specialists or consultants but 2 or perhaps 3 at that time confined their practice to a specialty. Dr. D. J. Wood, the distinguished ophthalmologist, was the pioneer in this direction. Later pioneers were Drs. J. Lückhoff (ear, nose and throat), H. Wessels (obstetrics and gynaecology) and D. P. Marais (specialist physician).

In the Medical Register of the present year (1 January 1954) there are 749 names of practitioners in Cape Town and suburbs, of whom 229 are on the various lists as specialists. Amongst the latter 59 are registered as physicians (including paediatricians), and the surgeons number 96 including those who practise special branches of the surgical art. There is a possibility that here and there a retired member of the profession may have been included in this list, but I have tried to avoid this and other possible sources of error. It is not my intention to discuss these figures or the policy behind them but merely to present them for comparison with the past.

MEDICAL CONGRESSES, SOCIETIES AND JOURNALS

The war which began in South Africa in 1899 had disrupted life in many ways, not least in the matter of medical practice. After the war great efforts were being made to return to normal. Medical congresses, which had been suspended during the war years, were resumed, and the 6th South African Medical Congress was held in 1904 in Cape Town under the presidency of Dr. E. S. Stevenson (afterwards Sir Edmund Stevenson).

In those days there was no South African Medical Association but, as in Australia and Canada, branches of the British Medical Association were formed in South Africa, and the Cape Western Branch of the B.M.A. had its centre in Cape Town. Later (1919) the Cape Western Branch (B.M.A.) purchased the old building at 35 Wale Street, Cape Town, which was used as the headquarters and library of the Branch until 1936, when it was replaced by the present building, which served as the joint home of the Branch and the Head Office and Journal of the Medical Association of South Africa.

In the early years of the century, whilst Johannesburg and Pretoria then had Medical Societies of their own, there were branches of the British Medical Association centred at several of the larger towns of the Cape and Natal, and the British Medical Journal was received by members.

Dr. Darley-Hartley (M.D., M.R.C.P.) for many years at the beginning of the century owned and skilfully edited the *South African Medical Record*, and through this journal exercised great influence in medical matters. It was not till 1927, that the Record was incorporated into the *Journal of the Medical Association of South Africa*, still under the editorship of Dr. Darley-Hartley.

Dr. Darley-Hartley had formerly practised in the Eastern Province. He used to tell how, during the Kaffir wars, he was allowed by the Native warriors to pass unmolested through their lines when on medical duty. He was in the habit of stressing in his Journal the high opinion he held of medical men in South

Africa, whether South African born or like himself immigrants. He held that a fine type of self-reliant practitioner had developed, able to cope with the exacting duties of practice in isolated areas.

DORP PRACTICE

The difficulties, hardships and discouragements of dorp practice are worthy of more than a passing reference, whilst the patience, faith and courage of our platteland peoples are almost beyond belief. First God and then the doctor was the rule, and the Bible was the trusted guide at all times. Those were the days of long horseback rides, Cape carts in flooded dongas, a whole day spent on a single visit, and of the absence of transport for sick or injured when, as was very seldom the case, a hospital within reasonable distance was available.

In her exquisite pictures of life and death in the Little Karoo, Pauline Smith (a doctor's daughter) gives a description of the transportation of a very sick woman, lying on her feather bed in an ox-cart, and depicts vividly some of the problems of these days.

The absence of trained nurses and midwives was a heavy handicap to rural doctoring. An old friend, Dr. John Brown (M.D., F.R.C.S.), told me a story anent the lack of safe childbirth. When he practised at Fraserburg he lived at the Pastorie and a handy man drove him in a Cape cart to visit patients at outlying farms. On one occasion they met at a gate a farmer and his wife to whom the young doctor was introduced. Later on his driver told him that he was glad to have had the opportunity of introducing him because this man was the only farmer in the district who had not married more than one wife. The explanation was that she was the only farmer's wife thereabouts who had never given birth to a child.

The *vroedvrou* (or *ouvrou*), the Sarah Gamp of the veld, no doubt had experience but she had no training or knowledge of how to avoid infection or to meet complications. Fortunately nowadays trained nurses and midwives are to be found in many country districts. A pioneer effort in this direction was made in 1910, when the King Edward VII Order of Nurses was founded for the placing of nurses and midwives in rural districts. Now the Government and other organizations help in supplying these modern Florence Nightingales, but many more are still needed.

The use of 'home remedies' was widespread, and faith was placed even in cancer 'cures'. In 1907 the Cape House of Assembly appointed a Select Committee to consider the claims of a popular cancer 'curer'. The remedies consisted usually of powerful caustics which caused extensive sloughing and often pain without hope of cure or even amelioration.

On one occasion the father of a family, one of whom I was treating, said to me, 'I too am a doctor. People come to my farm for treatment and I have only one remedy—buchu brandy. They like it and it seems to cure them'. Another farmer, when I told him what treatment I advised, said, 'I run from a doctor as a springbok runs from a gun'.

The life of the doctor in a dorp was certainly one of hardship. He had to contend with the results of isolation from kindred spirits and the difficulties with which he was faced in carrying out treatment and rendering full services to patients in scattered farmhouses and kraals. Is it to be wondered at if occasionally a dorp doctor failed to keep abreast of medical progress, or even that he sought consolation too often from the wine of the country? One medical pioneer motorist has recorded how motoring converted his professional life from a dreary drudgery to a comfortable proposition.

Dr. Darley-Hartley frequently stressed the necessity for combination amongst medical men not only for securing just remuneration, but for expressing the views of the profession, and preventing the loss of ethical tone which sometimes resulted from *res angusta domi* (i.e. insufficient income).

He made a passing humorous reference to a doctor in a dorp who was strongly recommended if he could be found when sober.

He also mentioned a dorp where there were three doctors of whom two had been placed by the Magistrate on the black list.

A SOUTH AFRICAN SCHOOL OF MEDICINE

At the 1904 Cape Town Medical Congress the most important paper read was that by Dr. Barnard Fuller on *A Medical School for South Africa*. Not for the first time was this project put before the medical profession. In 1898 Dr. W. J. Dodds, Medical Superintendent at the Valkenberg Institution, had devoted his presidential address at the Cape of Good Hope Branch of the B.M.A. to the need for a medical school in Cape Town. Dr. Fuller's advocacy of this scheme through the years was a great factor in promoting the fine Medical School of the University of Cape Town which exists today. At that time there was no university but the South African College was conducting excellent classes in what are now known as first-year medical subjects. Fuller now sought support for the introduction of professorships of Anatomy and Physiology.

The reception which this move received is interesting especially in view of future developments. Darley-Hartley said he was partially in favour of a South African medical school. He agreed with Cecil Rhodes, however, that it was best for a young man to get his early education in South Africa, but that it was also best for him to go 'home' to complete it amongst the venerable surroundings of England, Scotland and Ireland. He affirmed that 'Home universities broadened a man's experience and taught him to act like a gentleman'. Similar opinions, which sound absurd nowadays, were expressed, and Fuller's resolution was carried only after it had been amended.

At another meeting of the Branch this resolution was reversed and the General Medical Council and certain examining bodies in England were informed that there was 'strong opposition' to the establishment of these Chairs and recognition of local examinations. The Editor of the *Medical Record* wrote: 'we emphatically hold that until a complete medical curriculum can be established *en bloc* it is folly to talk about starting Chairs of anatomy and physiology'. In later years however Dr. Darley-Hartley gave full support to the embryonic Medical School.

As showing the difficulties in the early days of the Medical School, the Professor of Anatomy—Professor R. B. Thomson—in the first year or two could only teach osteology and surface anatomy till the Anatomy Act was passed in 1911. When this was accomplished, he and Professor W. A. Jolly (physiology) were able to give a full course in second-year subjects, which was recognized by the universities and examining bodies of the United Kingdom. The establishment of the Medical School of the Cape Town University was one of the greatest factors in the changes which have taken place in our profession. The Medical Association may take pride in having co-operated in these developments.

A SOUTH AFRICAN MEDICAL ASSOCIATION

In these early days it was felt that a purely South African organization was required in addition to the B.M.A. and this question was discussed during several congresses. A South African Committee of the B.M.A. was formed to deal with local problems. The writer was a member of this Committee and at one time Secretary. The idea of a South African Medical Association was first raised at the Medical Congress in 1906, when it was also proposed that the annual Medical Congress should be empowered to act for the profession in all South African matters.

These questions aroused a good deal of heated argument. At that time the B.M.A. was anxious to retain the South African unit and sent out to South Africa several representatives, to discuss the position, of whom Dr. Alfred Cox was one. At one stage the Association made a grant (unsought) of £2,000 to the funds of the South African branches. In the upshot it was not until 1928 that the Medical Association of South Africa was formed, and not until 1946 that the link with the B.M.A. was finally severed. One excellent scheme which was adopted at the time of which I am writing was that there should be an annual B.M.A. Lecture. The first was delivered in 1909 by Sir Kendal Franks, C.B. a leading Johannesburg surgeon. His subject was *The Position of the Medical Profession in South Africa*, and he concluded 'that whether we consider the question from the social, political or moral standpoint the position of our profession is deplorable'.

Reference was made in this lecture to questions of finance and

an interesting article was published in the *Record* on the financial position of practitioners, as follows:

'According to the Income Tax Report for 1908-9 the average assessable income of medical practitioners works out at £497, the average tax paid at £12 19s. 5d. In comparison, the average income of the legal profession is £494'.

An interesting insight is given into the question of fees charged in those days by a discussion held at one B.M.A. meeting held in Cape Town. It was reported that some practitioners, even seniors, charged fees as low as 5/- a visit. In the discussion one of the seniors said that he was not prepared to accept the 7/6 fee suggested as the usual charge, adding 'I will never agree to charge my patients more than I think they are able to pay'. There was no further discussion.

A case that aroused some interest was in connexion with the fee charged by a well-known practitioner who was called at night-time from the suburbs of Cape Town to Hout Bay to attend a confinement. The fee charged (10 guineas) was indignantly repudiated. The case came to court and although it was agreed that 5 guineas was the recognized fee for a confinement, the double charge was reasonable in view of the journey. Such cases were occasionally brought before the Colonial Medical Council and in the House of Assembly the question of doctors' fees were sometimes raised, especially by farmers.

THE CAPE MEDICAL COUNCIL

One of the most important duties of the Medical Council in those days was to deal with a series of difficult 'opium cases', in which it was alleged that medical men had prescribed opium which was used by addicts. In the end the Cape Assembly appointed a select committee on the 'Judicial Procedure of the Medical Council'. Eight doctors and a dentist gave evidence, and the *Medical Record* had leaders on *Law, Equity and the Medical Councils* and on *Medical Justice and State Law*. The Editor called attention to criticisms of the Council in the lay press, especially to an expression of doubt as to 'whether medical men, however well intentioned, have legal minds necessary for such enquiries'. It appeared from evidence given by Dr. C. C. Elliott and others that the *existence* of the Medical Council was at stake. Dr. Elliott stated that 'the universal feeling of the profession was that whilst the Medical Council should continue to exist, the Act required amendment'.

SCIENTIFIC WORK

It is impossible in reviewing the structure and development of our profession in these early days to pass over the excellent scientific work which was being carried on. This, it is true, was on a small scale compared to the present time, with its laboratories, professors, and highly specialized study and practice.

The Government Laboratory then situated in Parliament Street under the control of Dr. G. W. Robertson carried out valuable routine examinations, and also scientific investigations.

In 1906 Dr. D. J. Wood gave as his presidential address to our Branch *A Study of the treatment of bacterial diseases by vaccines*, which showed that his interest was not solely concentrated on his specialty. Some years later we had a lecture by Sir Almroth Wright on immunity. He started what was for us a new train of thought when he referred to the work of the distinguished Jewish Professor Ehrlich and his concept of *therapia sterilans magna* and stated that he believed that infections in future would probably be best treated by chemotherapy. In view of the success of Wright's antityphoid vaccine this prophesy astonished some of us.

The work of Dr. MacVicar at the Victoria Hospital, Lovedale, on tuberculosis and his writings on this subject were outstanding. He showed how widespread the infection was amongst the Bantu, and that they did not suffer from bovine tuberculosis when they used calabash milk because it was free from the active bacillus. At the Medical Congress of 1905 Dr. Ramsbottom read a striking paper on *The Conquest of South Africa by the tubercle bacillus*. He stated that this medical problem overshadowed all others. This is therefore no new problem.

Dr. Strachan, then a general practitioner in the Free State, did valuable original work on Malta Fever in South Africa.

The scientific study of leprosy was carried on by Drs. J. A.

Mitchell, Lindsay Sandes and others on Robben Island, Sandes contributing an original paper on the Surgery of Leprosy.

A new era was inaugurated when lectures on anatomical and physiological subjects were given by Professors Thomson and Jolly. Professor Jolly, Dean of the new Medical Faculty, was deeply interested in cardiac action and he established an apparatus (which occupied a whole room) for taking electrocardiographic tracings. He had spent some time in study in Holland under

Professor Einthoven, who was a pioneer in this branch of investigation.

From this time onwards close links have been established between our medical societies, the medical profession and our medical schools. It is to be hoped that they will continue and grow in strength year by year, for thus our profession will be enabled to provide the best possible medical services and advice to the people of South Africa, which is our chief end.

PAPERS PRESENTED AT THE RESEARCH FORUM, CAPE TOWN

Following is an abstract of a paper presented at the October meeting of Research Forum, Cape Town, at Groote Schuur Hospital by L. Vogelpoel and V. Schrire * on 'A new sign and some observations in the differentiation of Fallot's tetralogy from severe pulmonary stenosis with intact ventricular septum and reversed interatrial shunt':

The differentiation of Fallot's tetralogy from severe pulmonary stenosis with intact ventricular septum and reversed interatrial shunt is important because the surgical treatment is different.

A striking difference in the behaviour of the systolic murmur was found in the two conditions and this affords a new simple bedside method of diagnosis. In Fallot's tetralogy the systolic murmur, however soft or loud, starts soon after the first sound, reaches maximum intensity by mid-systole and then diminishes markedly, usually ending before the single loud, often palpable, second sound.

By contrast, in severe pulmonary stenosis with intact ventricular septum the systolic murmur is so prolonged that it extends beyond and drowns the normal aortic component of the very widely split second sound. It stops before the delayed diminutive pulmonary component, which may or may not be audible.

In severe pulmonary stenosis with intact septum the second heart sound is very widely split. In Fallot's tetralogy the second sound is usually single because the aortic sound is followed by an inaudible pulmonary sound. Additional auscultatory and phonocardiographic observations have been made which may prove

helpful in differential diagnosis. The mechanism underlying our findings has been discussed elsewhere (in press).

As reported under 'Passing Events' the next meeting will be held at 12 noon on Wednesday 3 November, when Dr. B. Bronte-Stewart will speak on 'Dietary aspects of experimental atherosclerosis and hypertension.'

* From the Cardiac Clinic, Department of Medicine, Groote Schuur Hospital, Cape Town.

The following papers have been presented during the present year:

- | | |
|------------|--|
| March: | Dr. L. Eales, <i>The electrolytes in 'nutritional' heart disease with particular reference to potassium.</i> |
| April: | Dr. W. P. U. Jackson, <i>A concept of diabetes.</i> |
| May: | Drs. V. Schrire and L. Vogelpoel, <i>The clinical and electrocardiographic differentiation of supraventricular and ventricular tachycardias with regular rhythm.</i> |
| June: | Dr. C. Merskey, <i>Control of anticoagulant therapy in thrombotic states.</i> |
| August: | Professor J. F. Brock, Dr. B. Bronte-Stewart and Dr. O. Budtz-Olsen, <i>Splenomegaly and serum proteins in Bushmen.</i> |
| September: | Dr. R. Sougin-Mibashan, <i>Metabolic studies of a new uricosuric agent.</i> |

ASSOCIATION NEWS : VERENIGINGSNUUS

MEETING OF THE GRIQUALAND WEST BRANCH

A meeting of the Griqualand West Branch of the Medical Association of South Africa was held on 30 September at Diskobolos, Kimberley. Dr. J. E. Vaughan Jones was in the Chair and 13 members attended.

Dr. E. D. du Plessis welcomed the members to Diskobolos and introduced some of the remedial staff members of the School for Physically Handicapped Boys. He described the set-up of the schools, what types of disabilities are admitted, and what special services are supplied. He proceeded to demonstrate the following cases:

1. *Pseudohypertrophic Muscular Dystrophy* in the early and late stages (two cases).
2. *Third-degree Scoliosis.*
3. *A Vascular Tumour of the Spinal Cord* (? hydatid).

4. *Haemophilia.* Two of the patient's mother's brothers had died from the disease in their teens, 3 of his own brothers had died from it in their teens, and he himself was severely crippled from recurrent haemorrhages into both knee joints.

5. *A Cerebral Palsy* case where the patient, a boy, had no use of his hands at all but had learnt to use a typewriter with his feet, to use a knife and fork with his feet and to drink out of a cup, lifting it to his mouth with his feet.

6. *Scheuermann's Disease* of the spine.

7. Another primary type of *Osteochondritis* of the spine.

Dr. C. de C. Murray Psychologist at the Diskobolos School delivered a short talk on 'The Psychology of the Physically Handicapped Child'.

The meeting concluded with the showing of two films.

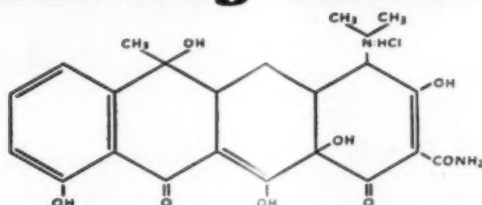
PASSING EVENTS : IN DIE VERBYGAAN

The Katherine Bishop Harman Prize. The Council of the British Medical Association is prepared to consider an award of the Katherine Bishop Harman Prize (founded in 1926) in the year 1955. The value of the Prize is £75. Its purpose is the encouragement of study and research directed to the diminution and avoidance of the risks to health and life arising in pregnancy and child-bearing. It will be awarded for the best essay submitted in open competition, competitors being left free to select the work they wish to present, provided this falls within the scope of the Prize.

The Prize will not be awarded if no essay submitted is of sufficient merit. Any registered medical practitioner in the British Commonwealth and Empire is eligible to compete.

Each essay must be typewritten or printed in English and accompanied by a detachable slip bearing the candidate's name. An entry form is required in connexion with this Competition, and a copy of the appropriate form can be obtained from the Secretary, to whom inquiries may also be addressed. Essays must be forwarded so as to reach the Secretary, British Medical Association.

something NEW



something NOTABLE

... in antibiotic therapy

Unique chemical composition is far from being the only noteworthy feature of ACHROMYCIN Tetracycline. This new antibiotic is more stable, more readily soluble and more easily absorbed from the gastro-intestinal tract than any of the broad-spectrum antibiotic in current use.

ACHROMYCIN is unsurpassed in its antibacterial range. But still more important is the fact that extensive clinical trials have shown ACHROMYCIN to be completely free of undesirable side-effects. The drug can therefore be given with safety, even for prolonged periods.

These and many other merits combine to make ACHROMYCIN an invaluable addition to the antibiotic armoury.

Achromycin^{*}

^{*} Regd. Trade Mark

Hydrochloride Tetracycline HCl Lederle



Capsules: 50 mg—vials of 25 and 100; 250 mg—vials of 8, 16, bottles of 100
 Spersoids† Dispersible Powder: Jars of 36 Gm. and 75 Gm.

Each 3.0 Gm. contains 50 mg. of Achromycin Tetracycline.

† Trade Mark



LEDERLE LABORATORIES DIVISION

Cyanamid Products Ltd.

Sole Distributor in South Africa:
 ALEX. LIPWORTH LTD.

BUSH HOUSE • ALDWYCH • LONDON • W.C.2
 • 1-3 DE VILLIERS STREET • JOHANNESBURG • SOUTH AFRICA



"All it says is—

CALTEX

IC-PLUS

PETROL"

CHI 54/4



Caltex IC-Plus Petrol

Protex — the Premium Motor Oil

Marfak — the Guaranteed Lubrication



as deadly to bacteria as nuclear fission

DECIQUAM 666

This powerful new quaternary ammonium compound supersedes the old-fashioned disinfectants and antiseptics.

EFFECTIVE Deciquam 666 has extremely potent anti-bacterial activity upon micro-organisms of all kinds. It is, moreover, effective at both high and low pH ranges and can be used as disinfectant, deodoriser, steriliser, or personal antiseptic.

SAFE Completely safe in normal dilutions, non-toxic and non-corrosive.

FUNGICIDAL Inhibits and kills yeasts of all kinds. For instance, is effective in prevention or treatment of Athlete's Foot.

DEODORANT Has a mild pleasant smell. Kills odours by destroying their source — microbial putrefaction.

ECONOMICAL Potent in even extreme dilutions and therefore economical for large-scale disinfection.

STABLE Does not deteriorate through light or heat, non-volatile, lastingly potents. Resists inactivation by anionic and organic materials.

USABLE IN HARD WATERS Unlike the black fluids and other disinfectants.

priced at 9/6 per $\frac{1}{2}$ gall. and 15/6 per gall.

Samples and literature obtainable from:

B. OWEN JONES LTD.

P.O. Box 36, Boksburg, P.O. Box 8127, Johannesburg,
P.O. Box 679, East London, P.O. Box 434, Cape Town.

tion House, Tavistock Square, London, W.C. 1, not later than 31 December 1954.

* * *

At a meeting of the Worcester division of the Cape Western Branch held at the Worcester Hospital on 17 September 1954, Professor J. F. P. Erasmus, Dr. J. H. Louw and Dr. D. J. du Plessis, from the Department of Surgery, University of Cape Town, addressed the Division on the subject of *The Acute Abdomen*. The addresses were found most interesting and instructive, and the speakers were accorded enthusiastic reception.

* * *

Research Forum, Cape Town. The next meeting of Research Forum will be held at 12 noon on Wednesday, 3 November, in the large A floor lecture theatre, Groote Schuur Hospital, Cape Town. Dr. B. Bronte-Stewart will speak on 'Dietary aspects of experimental atherosclerosis and hypertension'.

Research Forum is held on the 1st Wednesday of the month during University term at 12 noon at Groote Schuur Hospital.

It is intended for presentation of original research (not necessarily completed) in the broad field of medicine. Attendance is restricted to medical practitioners, members of staff of the University of Cape Town and workers in associated sciences. Further information may be obtained from Dr. C. Merskey, Groote Schuur Hospital.

* * *

Dr. Harry M. Pretorius, M.R.C.O.G., has joined Dr. Harold Renton, M.D., M.R.C.O.G., in partnership as a Gynaecologist and Obstetrician, at 82-89 Trust Buildings, Gardiner Street, Durban. Telephone: 2-6153 (consulting rooms) and 6-4855 (residence).

* * *

Dr. Harry M. Pretorius, M.R.C.O.G., praktiseer nou as Verloskundige en Ginekoloog in vennootskap met dr. Harold Renton, M.D., M.R.C.O.G., te Trust-gebou 82-89, Gardinerstraat, Durban. Telefoon: 2-6153 (spreekkamers) en 6-4855 (woning).

BOOK REVIEWS : BOEKRESENSIES

PHARMACOLOGY

The Essentials of Materia Medica, Pharmacology and Therapeutics. By R. H. Micks, M.D. (Dubl.), F.R.C.P.I. (Pp. 433+x. 24s.) London: J. & A. Churchill Ltd. 1954.

Contents: 1. General Principles. 2. Narcotic Action. 3. Opium and Morphine. 4. Hypnotics and Anticonvulsants. 5. General Anaesthesia and Anaesthetics. 6. Convulsants and Analeptics. 7. Adrenaline and Sympathomimetic Drugs. 8. Acetylcholine. 9. The Antihistamines. 10. Local Anaesthetics. 11. Salicylates and other Mild Analgesics. 12. Drugs used in the Treatment of Heart Failure. Digitalis, Quinidine, Procaine Amide, Nitrites. 13. Diuretics. The Treatment of Oedema. 14. Purgatives. The Treatment of Peptic Ulcer. 15. Thyroid. Iodine. Antithyroid Drugs. 16. Calcium. Parathyroid. Vitamin D. 17. Drugs concerned in the Treatment of Anaemia. Iron. Cyanocobalamin. Liver. Folic Acid. 18. The Coagulation of Blood. 19. Vitamins A, E and the B Complex. 20. Gonadotrophic and Sex Hormones. 21. Water and Electrolyte Depletion. 22. ACTH and Adrenal Cortical Steroids. 23. The Antibiotics. 34. The Sulphonamides. 35. The Use of the Antimicrobial Drugs. 36. Metalloids and Heavy Metals. 37. Antimalarial Drugs and Amoebicides. 38. Anthelmintics. 39. Cytotoxic Drugs. 40. Prescribing. Index.

It is 4 years since the last edition of this well-known book appeared and, since rapid changes are taking place over a wide field in pharmacology, most of it has been rewritten to incorporate recent advances. The book has been replanned. It will still prove popular to students and to physicians for information on the principles of pharmacology and drug therapy and for guidance in the choice and administration of drugs.

The presentation is intended 'to teach the subject rather than to expound it'. The drugs that are considered are those regarded as of real therapeutic value and accepted as part of practice in teaching hospitals. Many drugs have not been considered which most teachers of pharmacology would discuss in a systematic course of instruction in the subject. There are certain omissions which have struck the reviewer's attention; some of these are mentioned below, and are numbered for identification.

It is stated in the preface that the nomenclature of the 1953 British Pharmacopoeia has been followed. No mention (1) however is made in the text of the fact that Injection of Posterior Pituitary, and pills (e.g. Pill of Aloes and Blaud's Pill) are no longer 'official'. It is interesting that no mention (2) is made of the use (or misuse) of amphetamine compounds for obesity. The classification of drugs always presents difficulty; ascorbic acid is here considered in the chapter dealing with coagulation of the blood and not in the section on vitamins. Vitamin P is briefly considered; it might well have been omitted since its existence is no longer regarded as established and it has been recommended that the term be no longer employed.

As regards the fate of ultra-short-acting barbiturates, e.g. thiopentone, (3) recent work has shown that their metabolic transformation is slow but that they rapidly leave the circulation to become localized in body fat. For the treatment of agranulocytosis produced by arsenic and gold (4) dimercaprol is useful. Whereas neostigmine is contra-indicated as an antidote for suxamethonium in those cases where the relaxant produces prolonged apnoea, (5) fresh whole blood or plasma should be used to counter-

act the apnoea. It may be mentioned here that antihistaminic drugs, although widely used on the skin, (6) are not acceptable to *New and Nonofficial Remedies* (U.S.A.) because of the danger of sensitization.

As regards progestogens, (7) amongst other uses success has followed the administration of the hormone in the premenstrual syndrome; (8) ethisterone is the official name for the orally effective compound. In the section dealing with the treatment of narcotic poisoning there is an arresting sentence: 'It is very doubtful whether these (analeptic drugs) have ever saved a life'.

In order to provide a book of convenient size and price, and to make the task of learning as easy as possible a certain number of drugs must be selected by teachers for detailed consideration. This has been done in this book. Many drugs could only be dealt with briefly. In some countries more information will be required about certain drugs e.g. antimalarials, amoebicides, than is given in this book, which is primarily for British readers.

This book gives a very readable account of modern drugs used in practice and should prove as popular as its predecessors.

N.S.

EXPERIMENTAL DIABETES

Experimental Diabetes and its Relation to the Clinical Disease. A Symposium Organized by the Council for International Organizations of Medical Sciences. Edited by J. F. Hoet, G. F. Young, J. F. Delafresnaye and G. Howard Smith. (Pp. 352 + ix, with figures. 35s.) Oxford: Blackwell Scientific Publications. 1954.

Contents: 1. Chairman's Opening Remarks. 2. On the Islets of Langerhans. 3. Glucagon, the Hyperglycaemic-Glycogenolytic Factor of the Pancreas. 4. Action of the Hyperglycaemic Factor (Glucagon) of the Pancreas. 5. Alloxan Diabetes and the Mechanism of Beta-Cell Damage by Chemical Agents. 6. Changes in the Blood Sugar Level During the First Hours after Alloxan Injection. 7. Diabetes and Biological Oxidation of Uric Acid. 8. Does Alloxan Play a Part in the Pathogenesis of Diabetes Mellitus? 9. The Effects of Adrenal Cortical Steroids on Carbohydrate Metabolism in Man. 10. The Adrenal Cortex and Carbohydrate Metabolism. 11. The Adrenals and Growth Hormone Diabetes. 12. The Structure of Glycogen and Enzyme Patterns in Glycogen Storage Disease. 13. Growth Hormone and General Metabolism. 14. Relationships of Growth Hormone to Diabetes. 15. Insulin and Growth Hormone. 16. Nitrogen Retention and the Action of Insulin. 17. Problems concerning the Absorption of Insulin from Human Subcutaneous Tissue. 18. The Incidence of Diabetes and Heredity. 19. Human and Experimental Diabetes. 20. A Study of the Diabetogenic Action of Pregnancy. 21. Concluding Remarks. 22. Chairman's Summing-Up. Index.

This symposium was held last year in Leiden and was arranged to follow the meeting of the International Diabetes Federation. This and the preceding Ciba colloquium on carbohydrate metabolism held in London accounts for the array of international talent which contributed and made 1953 an outstanding year in carbohydrate research.

The discussions on the experimental production of diabetes revolved around the action of 3 substances—glucagon, alloxan and growth hormone. Glucagon, the hormone of the α -cells of the pancreatic islets, mobilizes glycogen from the liver, but it seems unlikely that it will prove to be a cause of clinical diabetes. Alloxan

damages the β -cells of the islets, probably by interfering with the sulphhydryl groups of essential cell-enzymes.

There was a debate on whether alloxan occurs naturally in the body and it was suggested that it may be secreted by the gut after carbohydrate meals and act as a hormone eliciting the post-prandial secretion of insulin. Another hypothesis was that substances related to alloxan may be formed from purines in the body and may act as natural diabetogenic agents. After discussion it was decided that there is as yet no certain evidence that growth hormone can be prepared without diabetogenic action but it seems certain that its action on growth depends on extra insulin production.

Shorter sections concerned the absorption of insulin from subcutaneous tissues; steroid diabetes as sometimes seen in Cushing's syndrome and after ACTH and cortisone; heredity and diabetes, and the increasing realization of the importance of pregnancy in relation to pre-diabetes.

This is a book by experts and will be of most interest to physiologists and clinicians with a special knowledge of recent work on carbohydrate metabolism and diabetes.

G.C.L.

REFRACTION

The Practice of Refraction by Sir Stewart Duke-Elder, K.C.V.O., M.A., D.Sc., Ph.D., LL.D., M.D., D.M., F.R.C.S., F.A.C.S. Sixth Edition. (Pp. 335 with 239 illustrations. 21s.). London: J. & A. Churchill, Ltd. 1954.

Contents: Part I. Introductory. 1. Eye-Strain. Part II. 2. The Principles of Refraction. 3. The Refraction of the Eye. 4. Anomalies of Refraction—Hypermetropia. 5. Anomalies of Refraction—Myopia. 6. Anomalies of Refraction—Astigmatism. 7. Anomalies of Refraction—Anisometropia. 8. Anomalies of Refraction—Aphakia. 9. Anomalies of Refraction—Aniseikonia. 10. Changes in Refraction. Part III. 11. Accommodation. 12. Convergence. 13. Presbyopia. 14. Anomalies of Accommodation. 15. Anomalies of Convergence. Part IV. 16. Orthophoria. 17. Heterophoria. 18. Heterotropia. Part V. 19. Ophthalmological Examination. 20. Visual Acuity. 21. Visual Acuity. 22. Objective Methods of Refraction. 23. Objective Verification of

the Refraction, and the Testing of the Muscular Equilibrium. Part VI. 24. The Making and Fitting of Spectacles. 25. Contact Lenses. Appendices. Index.

Sir Stewart Duke-Elder has that rare ability to infuse into his writing a personality and lack of complication which makes all his work essentially readable. Few medical men are at home with mathematical formulae; to most ophthalmologists the study of optics, so important to the understanding and practice of refraction, was a necessary hardship. In this book—I quote—"a simple and essentially non-mathematical form of presentation has been adopted", and, I may add, with success.

Recent advances in knowledge and new interpretations have resulted in a number of changes in this edition, the most important of which concern contact lenses; there is a separate new chapter devoted to this subject.

Chapter 1, on 'Eyestrain', is a stimulating introduction, and if the author appears both to run with the hare and hunt with the hounds in his discussion of its treatment, he does what he clearly intends to do in providing food for much thought on this controversial symptom.

It is a trifle disconcerting to step from this subject into Part II and the study of optics, but it has to be done, and here, at least, it is done simply.

The making and fitting of spectacles is a subject too often overlooked by the busy practitioner, so that Part VI, which commences by dealing with this subject, is welcome, and, in a few pages, provides much useful information; in addition, we in this country must find interest in Sir Stewart's views on the close working relationship desirable between ophthalmologist and optician.

In the appendix are to be found tables of formulae for various lens-forms and lists of visual requirements for British and American fighting services and merchant marine; so far the Dominion Services have not been so honoured, but perhaps the standards differ little.

In short, a thoroughly satisfactory book.

S.C.A.

CORRESPONDENCE : BRIEWERUBRIEK

STERILIZATION OF WOMEN

To the Editor: I read with interest the paper presented at the South African Medical Congress at Port Elizabeth, *Sterilization of Women* by Dr. R. Lance Impey.¹ He has presented the subject as viewed by a gynaecologist. Judging from the material presented, it is apparent that he holds that sterilization of a woman for reasons other than medical, is possibly not legal and probably not ethical. Most of the facts presented were to support this contention. I do believe, however, that a great many of us hold views not quite in accord with those expressed.

The law in South Africa is certainly not clear on whether sterilization is a legally acceptable procedure or not. The opinion¹ obtained by the Transvaal Provincial Administration bears a little closer scrutiny from the medical point of view.

In drawing a parallel between sterilization and the amputation of a healthy limb, it does appear that the lawyers are a 'little off beam'. Why didn't they choose the neck instead? Then it would obviously be murder, which none of us would contemplate! What doctor has ever been confronted by a request from a sane person for the amputation of an arm? but all of us have fairly frequently been confronted by the request from a sane married couple for sterilization—more often than not for economic reasons; so that merely on the grounds of 'patients request' the two do not bear comparison. Most, if not all, these requests are seen as a very real need for their future economic, family and mutual well-being. None in my limited experience has ever been frivolous. Had the comparison been drawn with the surgical procedure of circumcision of the new-born infant, I think the parallel would have been closer. Are not many, if not most, circumcisions performed, not on medical grounds, but purely and simply because of parental request? Is not healthy tissue removed without the patient having any say in the matter at all? Yet I do not think that this operation is regarded as either illegal or unethical. I hope, Sir, to be consistent, that circumcisions are no longer permitted at the Provincial Hospital referred to on any grounds other than medical.

It does appear too, that in England the legal position is also

still very uncertain: 'Lord Justice Denning went on to make some general observations, which are likely to raise considerable controversy: "When a sterilization operation was done with a man's consent for a just cause, it was quite lawful, as when done to prevent the transmission of a hereditary disease, but when it was done without just cause or excuse it was unlawful even though the man consented to it" . . . The Master of the Rolls and Lord Justice Hodson dissociated themselves from Lord Justice Denning's view that, in the absence of some "just cause or excuse" an operation for sterilization is an unlawful assault, an act criminal in itself to which consent provides no answer or plea . . . The wife's petition was dismissed in consequence of the majority decision. As leave to appeal to the House of Lords was refused, we shall have no chance to know if Lord Justice Denning was right after all. For the present it seems we must believe he was wrong'.²

'Under the present Danish law one of the categories of persons who may be sterilized if it appears to be indicated for social reasons is (i) feeble-minded persons, if regarded as incapable of adequately providing for or educating their offspring.³ It does seem that this is but half a step from normal persons if regarded as being incapable of adequately providing for or educating their offspring.

THE ETHICAL ASPECT

One agrees whole-heartedly with Dr. Impey that we should be guided by the traditions and high ethical code of the profession of medicine. While perhaps the primary duty of medicine is to save life, it is equally concerned with the relief of both physical and mental suffering within the framework of the law, and the concepts of the Hippocratic Oath. Where, according to the modern version, a physician should maintain the utmost respect for human life from the time of conception, it does not, according to either the old or the modern version, forbid the prevention of conception either temporarily or permanently.

While one of the fundamental laws of humanity is procreation, and no one will dispute the fact that 'one of the basic elements in the very definition of marriage, as adopted in our Law', is⁴ "for

the purpose of procreating and rearing children . . . " few will dispute that the procreation and rearing of children is not the sole purpose of marriage, and many hold the view that the sexual act has functions other than its undisputed primary function—procreation. Walter Stokes⁴ says: "Those whom nature will not favour with parenthood have no reason to make of it a major tragedy. They can still have the basic thing in marriage; their affectionate relationship with each other".

In my opinion, a request by a married couple, who have borne as many children as their circumstance will allow, for sterilization of one of the partners of the marriage is a very reasonable request. Here particularly the general practitioner has a decided advantage, if he is the family doctor, adviser and friend. Contraceptive procedures are quite satisfactory in the hands of intelligent and responsible people, assisted by professional advice. "Lack of education, superstition and alcoholism are the chief obstacles to success in the use of present contraceptive methods. We have reason to believe that surgical sterilization (without desexing) of both man and woman may in the future play a considerable role in limiting human fertility. There is a current tendency to justify sterilization upon strong considerations of general family health and welfare".⁵ If ethically, morally and legally the use of contraceptive methods is correct, then it would appear that under certain circumstances sterilization does not depart from this standard.

There must be few general practitioners who have not been forcibly struck by the deterioration of family unity and spirit in homes they visit, with the advent of an 'unwanted' child, or, worse still, children. I would like to qualify the term 'unwanted' as used here, to mean children added to an already big family, which would stretch to breaking point the already strained family budget. No family can thrive when faced with poverty, disease, malnutrition, overcrowding, unhygienic surroundings, and all the indignities attending such a mode of living.

The mother is the focal point and guiding light of every family. Destroy her morale and courage by overloading the heavy burden she already carries; break her spirit and bring out all her neuroses by the constant fear of unwanted pregnancies; and the cohesive force of the family will be lost, and the family will disintegrate.

Richard W. Te Linde, Professor of Gynaecology and Obstetrics at the Johns Hopkins Hospital, says: "Economic distress is probably the phase of sterilization, about which there exists the greatest controversy. The author believes that within certain limitations it constitutes a legitimate indication. To deny a healthy couple the privilege of parenthood of two or three healthy children simply on the basis of poverty would be unjustifiable, but to deny a couple the privilege of limiting their family at their request when their economic burden is already more than they can bear comfortably is also unjustifiable . . . The right to a decent rearing seems to us nearer to fundamental justice than the claim for poverty-stricken parents to have unlimited offspring. Sterilization of one or other of the couple is the surest solution".⁶

Dr. Impey claims that 'the woman who has a series of pregnancies within a short time has lost her sense of perspective, and is, more or less, temporarily deranged, and cannot be expected to arrive at a reasoned or reasonable decision'.⁷ With this I agree, but would go further and add, 'from which she might never recover'. How many become neurotic, possibly even psychotic! Here again the general practitioner does not lose contact, and with the passing of time finds that a happy wife and good mother has become a frigid and disagreeable spouse, a neglectful and distracted mother, struggling through life until the menopause, haunted by the ever-present fear of unacceptable pregnancies. Some never reach their Utopia—the menopause and no more pregnancies—and, for many of those that do, it is too late; they remain neurotic till the end of their lives.

'Probably Freud's discovery of the important part which the sexual instinct plays in the formation of the neurotic's reactions, and of the great influence which this innate force plays in the thoughts, feelings and behaviour of every individual, startled the world more than any other piece of research . . . First of all one must remember that the sexual instinct is a natural force, which causes no trouble when given a natural outlet . . . Sex therefore is a force with which the medical profession must reckon only when it is dammed up'.⁸

'Great multiparity has been shown by Eastman to be an important factor in increasing maternal mortality. In a study of 45,145 deliveries at the Johns Hopkins Hospital he found that

the maternal mortality rose sharply after the 8th pregnancy. In the lower brackets (1-6) it ranged between 3.55 and 3.78 per 1,000 deliveries, but it soared to 11.73 per 1,000 with a family of 9 or more . . . Such evidence produced by Eastman would seem ample justification for limiting the family'.⁹

"Dull children are to be found in large families, and intelligent children in small ones. Since large families are now commonest among the duller—or anyhow the least successful—members of our society, and since their children may inherit their dullness, we are perhaps threatened by a decline in national intelligence".¹⁰

A request by parents for the application of medical skill and knowledge in the limitation of family size, to maintain a reasonable economic and intellectual standard, and to prevent deterioration of the mother's health, is a justifiable request. It should be neither ethically or legally wrong for a doctor (or doctors) to accede to this request within certain limitations. Possibly even, it might be his duty towards the community to do so.

A DOCTOR'S OBLIGATION TO THE STATE

Finally, what are a doctor's obligations to the state? T. F. Fox, in an article *Conflict of Loyalties*, writes: "The practising doctor is not a servant of the State or an instrument of government, and as a doctor he has no special duty to the State . . . In principle surely the greatest danger to be feared from the assimilation of medicine into the machinery of the State is that it may be applied not to its proper function—but to destruction rather than the preservation of life . . . We are living in a phase of history when national States—often quite arbitrary and recent aggregations of races—insist on exclusive loyalty from their subjects. They are apt to demand not only the things that are Caesar's, but also those that are God's. Yet, if we keep our sense of biological and historical perspective, we must recognize that what really matters can never be the State but only the people who compose it. In medicine we have a profession specifically devised for serving these people; for serving them directly, not indirectly; for serving them without harming them; for serving them by means which do not need the justification of some remote end".¹¹

If we are to serve the people who compose the State, and in particular the mothers, through whose suffering, the race is perpetuated—to preserve their health both physical and mental—then sterilization of some of those mothers, under certain circumstances, should be one of the instruments in medical hands to maintain a healthy family and nation.

W. Blignaut

Lorne Street
Estcourt
Natal
16 October 1954

1. Impey, R. L. (1954): S. Afr. Med. J., **28**, 872.
2. *Medicine and the Law* (1954): Lancet, **1**, 286.
3. The British Encyclopaedia of Medical Practice, 2nd ed., vol. II, p. 573. London: Butterworth & Co. (Publishers) Ltd.
4. Stokes, W. R. (1949): *Modern Pattern for Marriage*, p. 63. London: Reinhardt and Evans Ltd.
5. *Idem*, p. 80.
6. Te Linde, R. W. (1946): *Operative Gynaecology*, p. 534. Philadelphia: J. B. Lippincott Co.
7. Impey, R. L., *loc. cit.*, p. 873.
8. Dunlop, Davidson and McNee (1949): *Textbook of Medical Treatment*, pp. 899-900. Edinburgh: E. & S. Livingstone Ltd.
9. Annotation (1953): *Family Size and Intelligence*, Lancet, **2**, 337.
10. Fox, T. F. (1954): Lancet, **2**, 418.

THE RESULT OF THE POLL

To the Editor: The National General Practitioners Group deplores the Editorial 'The Result of the Poll' appearing in the issue S.A. Medical Journal of 13 September.

It regards this as biased, unfair and misleading and that it was unwise on your part to have anticipated the deliberations of Federal Council on the results of the referendum.

E. Meltzer
Acting Hon. Sec. (Treasurer)
National General Practitioners Group
P.O. Box 536
Benoni
8 October 1954

TEKORT AAN VERPLEEGSTERS

Aan die Redakteur: In die daggers onlangs was 'n berig waarin die Provinsiale Sekretaris sy bedenkinge uitspreek oor die ernstige tekort aan verpleegsters. Aangesien dit 'n saak is wat ons as beroep baie dringend raak, dink ek dit is ons plig om ernstige aandag te wy aan die oplossing van die probleem.

Myns insiens is daar een faktor wat jong meisies van goeie inbors—die tipe wat ons graag as verpleegsters wil hê—tot 'n groot mate afskrik van die werk. Ek praat naamlik van die feit dat jong onervare leerlingverpleegsters verwag word om die ruwe en onsmaklike werk te doen in die kleurlingmansale van ons hospitale. Hulle word blootgestel aan onredelike vernedering en ek verwonder my dat, ten spyte hiervan, daar nog so 'n groot persentasie van die meisies volhard met hulle opleiding. Dit getuig van 'n groot liefde vir hulle werk, maar ek dink werklik daar word te veel van hulle verwag. Laat ons as 'n beroep, ons wat die intieme kennis het van wat aangaan vandag, ons stem laat hoor en sorg dat hierdie saak reggemaak word. Die oplossing is natuurlik voor die hand liggend, in die opleiding van nie-blankes—mans sowel as vrouens. Die geleentheid hiervoor behoort veral te baat geneem word in die nuwe hospitale wat gebou word.

Die verwydering van hierdie struikelblok sal nie alleen die lewe van ons verpleegsters veraangenaam nie, maar sal ook talke jong meisies lok tot die beroep.

P. D. Nel

Sanlam-geboue
Stockenstromstraat
Worcester, K.P.
13 Oktober 1954

TEETHING PATTERNS IN INFANCY

To the Editor: While Dr. James¹ is satisfied, on clinical grounds, that the process of teething causes symptoms, he finds difficulty in establishing 'any relationship between the teething process and the morbid process causing the symptoms'. It seems to the writer that the 'natural' relationship would be recognized, and the difficulty overcome, if we reconciled the physiological process of teething and the natural quantitative variations (from child to child) in sub-epithelial fibrous tissue overlying dental buds, with the anatomical fact that the sensory nerve supply of the gums cannot conceivably be omitted in any consideration of 'processes', physiological or otherwise, in this tissue.

On this basis the 'ease or difficulty with which the teeth penetrate the overlying gingival tissue', taken in conjunction with the clinical fact that each infant recurrently manifests its own particular teething pattern, strongly suggests a 'natural' relationship, since symptom patterns are grounded in the 'structure' (anatomy) of the particular infant.

After all there can be no 'illness' apart from the individual experiencing it, and it is thus understandable that 'easy' penetration is relatively asymptomatic, difficult penetration patho-physiological, causing, e.g., red swollen gums plus 'other' symptoms. In the latter circumstances direct clinical observation verifies increased blood supply and permeability (red, swollen gums), direct sensory nerve irritation (hand constantly in mouth), and localized tissue damage (eruption of teeth), with the liberation of histamine.

All damaged or injured tissues liberate histamine. Since this substance can provoke asthma, vomiting, diarrhoea, increased salivation, flushing and whealing, may not the various teething syndromes be explicable on the basis of the 'shock tissues' involved? After all, the 'watery eye, runny nose, flushed cheek and disturbed sleep' combination has considerable clinical resemblance to histamine cephalalgia, and restlessness, fretfulness, somnolence and convulsions are all possible from the vascular effects and increased permeability caused by histamine. As a practical philosophical 'aside' we might remember that adrenaline counteracts histamine action, and so a 'shot' might well help patient and interpretation alike.

But how explain the temperature, otitis media and bronchitis? Here histamine-induced tubal swelling, sinal blockade and tubal and bronchiolar swelling and obstruction favour retention, the supervision of secondary infection, and temperatures associated with sinusitis, otitis media, and an asthmatic type of bronchitis.

It has been pointed out that the sensory nerve supply of the gums cannot conceivably be omitted from any deliberations on the teething process. As the sensory portion of the Vth cranial

nerve supplies the affected gums in question, it is not so surprising that insomnia, crying spells, fretfulness, restlessness should characterize the infants' attitude to a toothache. Do not forget either that the descending root of cranial V arborizes in the medulla in the region of the motor nucleus of cranial X, the vagus, and that the clinical suddenness and spontaneity of the respiratory and gastro-intestinal expressions of the teething process have this possible 'reflex' basis. Nor is the commonest of all teething symptoms, namely salivation, outside the province of the versatile fifth. It is quite true that the salivary glands are under the control of the autonomic nervous system, but it is also a fact that stimulation of the ordinary sensory nerves of the mouth, i.e. those fibres conveying sensations of touch, pain and temperature, also evoke the flow of saliva.

Again may not taste be involved when a gum is red and swollen? After all, the tastes we experience usually arise from a combination of one or more of the 4 fundamental sensations of taste (sweet, bitter, sour and salty) plus that aroused by stimulation of the ordinary sensory nerves of the mouth. Thus beside the 'feel', 'pain' and 'heat' of the swollen congested gum, the saltiness of exuded serous and tissue fluids may be responsible for stimulation of the salivary glands directly via the chorda tympani. This nerve, which supplies taste fibres to the anterior two-thirds of the tongue, where at the tip and sides taste receptors most sensitive to saltiness are located, is also the secretory nerve of the salivary glands, and the nerve pathway for the almost diagnostic drooling characterizing the process of teething. Since the Vth nerve obviously plays a part in adjudging and estimating the environment, it would indeed be remarkable if it were not disturbed by pressure and hyperemia—all other nerves are—and likewise significantly relieved when these physical signs disappear with 'eruption'.

On the basis, therefore, of the infant's own gum structure, and the common sensory nerve supply and common natural product of tissue injury, histamine, liberated during the process of teething, the natural relationships existing between the teething process and the morbid process causing the symptoms can be recognized.

M. Glass

620 Boston House
Strand Street
Cape Town

I. James, T. (1954): S. Afr. Med. J., 28, 890 (16 October).

IT'S TEETHIN' HARD
Old Style

To the Editor:

If it coughs,
if it wheezes,
if it sniffs,
if it sneezes,
it's teethin'.

If it's tummy works,
if it's got the jerks,
if little spots
is what it's got,
it's teethin'.

If it's cheeks are red,
if it wets the bed,
if it yells and screams,
if it has bad dreams,
it's teethin'.

Chorus
If diagnosis is in doubt,
don't go for measles or for gout,
it's teethin'.

1954 Version

But what
O pray,
would Selye say?
'I guess,
it's stress,
is teethin'.

I. Mirvish

Cape Town
18 October 1954

Important in the field of dermatology...



... For exudatory dermatoses

SICCOLAM is a unique preparation of adsorbent oxides in a fat-free base which allays irritation and promotes rapid drying and healing of exudatory dermatoses. It may be safely applied before a final diagnosis has been made without prejudice to subsequent treatment.

Containers of 2 oz., 4 oz. and 1 lb.

BRITISH DRUG HOUSES (SOUTH AFRICA) (PTY.) LTD. 123 JEPPE STREET, JOHANNESBURG

Sic/SAT/51/1

Roter Gastric Ulcer Tablets

are applied with still increasing success for the treatment of gastric and duodenal ulcer; acute and chronic gastritis hyperchlorhydria.

The classic pharmacology of bismuthsalts has been improved by the Pharmaceutical Works "Rotor" in such a way, that really can be spoken of a new principle in the therapy of the peptic ulcer.

This therapy has proved its extraordinary value by extensive application in medical practice.

You are invited to write for full information and a clinical trial supply.

IMPORTERS

HARRY DELEEuw CO. (PTY.) LTD.

P.O. BOX 7, Maraisburg, Transvaal, South Africa.

Distributors for South Africa and S.W.A.:

ALEX LIPWORTH LTD. Johannesburg, P.O. Box 4461; Cape Town, P.O. Box 4838; Durban, P.O. Box 1988.

Distributors for Rhodesia: GEDDES LTD. Bulawayo, P.O. Box 877; Salisbury P.O. Box 1691.



Please Support Our Advertisers — Ondersteun Asseblief Ons Adverteerders

Introducing

H I C O S E E N

H O M M E L

A new, highly effective expectorant on an original basis

The principal constituent of 'HICOSEEN' is 2-Diethylaminoethyl-phenylethyl-acetate, synthesized by Hommel and for the first time clinically used. It acts broncholytically and at the same time sedatively on the cough reflex.

'Hicoseen' provides the basic requirements of anti-tussic therapy: repression of cough reflex and promotion of expectoration. These are accomplished with a very high degree of compatibility.



PHARMACOLOGY

Absence of side-effects, including drowsiness, is of outstanding importance. The respiratory centre not being acted on in any way, the cough reflex is probably influenced by a mechanism different from that of morphine alkaloids. 'Hicoseen' contains such a small dose of codeine phosphate that even high overdosage is innocuous.

COMPOSITION

2-Diethylaminoethyl-phenylethyl-acetate	0.1%
Codeine phosphate	0.08%
Guaiacol albuminate	5.25%
<i>in pleasantly flavoured syrup</i>	

INDICATIONS

Specific in cough irritation, bronchial catarrh, bronchitis, tracheo-bronchitis in emphysema and pulmonary tuberculosis.

DOSAGE

Adults: 2 to 4 tablespoonfuls; in cases of cough irritation 1 to 10 teaspoonfuls daily.
Children: according to age and number of cough paroxysms 3 to 5 tea- or dessertspoonfuls daily.

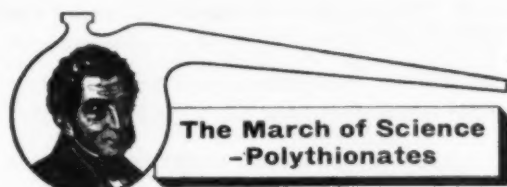
PRESENTATION

'Hicoseen' Syrup is available in bottles containing 4 fluid oz; also in 16 fluid oz. bottles for dispensing.

PROFESSIONAL SAMPLE AND LITERATURE ON REQUEST

HOMMEL'S HÆMATOGEN & DRUG CO., 121 Norwood Road, London S.E.24

Our Sole Agents for SOUTH AFRICA: MESSRS. LENNON LIMITED. P.O. Box 39, Cape Town. P.O. Box 24, Port Elizabeth. P.O. Box 266, Durban, Natal. P.O. Box 928, Johannesburg, Transvaal. P.O. Box 76, East London. P.O. Box 1102, Bulawayo, Southern Rhodesia. P.O. Box 379, Salisbury, Southern Rhodesia.



The March of Science -Polythionates

Heinrich Wilhelm Ferdinand Wackenroder 1798 - 1854

The chemistry of polythionates, intimately connected with that of colloidal sulphur, goes back to the beginning of the nineteenth century when J. Dalton, the Manchester philosopher, investigated the reaction of hydrogen sulphide and sulphur dioxide in aqueous solution.

A considerable advance was made by Heinrich Wilhelm Ferdinand Wackenroder, a professor of pharmacy in the University of Jena at a time when inorganic chemistry was little more than the handmaid of medicine and the arts.

In 1846 he first showed how to produce a solution containing what we now know as polythionic acids, but free from colloidal sulphur. Since that time "Wackenroder's solution" has fascinated and bewildered succeeding generations of chemists by the complexity and variability of its composition—but also by its instability.

The necessity for the therapeutic evaluation of the polythionates followed the discovery that bactericidal and fungicidal effects, formerly attributed to elemental sulphur, were, in fact, a property of the polythionates; but stability in solution has, until now, proved the stumbling-block for research workers.

The difficulty has at last been overcome and now, for the first time in this country, we present, in "Dermasulf" a completely stable polythionate of known composition.

Medically and cosmetically entirely acceptable, Dermasulf is composed of complex polythionic acids; $H_2S_xO_4$ (x is principally 4 or 5) and their salts. It is available as a 3½% solution. The polythionate content as tetra- and penta-thionate, of the 3½% solution, is equivalent to 1½% elemental sulphur. The pH is approximately 3.4.

Dermasulf is available in 2 oz. bottles. A specimen and full literature will gladly be sent on request.

DERMASULF

A completely acceptable, stable solution of polythionates for the treatment of all dermatological conditions where sulphur is known to be of value.



THE CROOKES LABORATORIES LIMITED · PARK ROYAL · LONDON N-W-10
P.O. BOX 1573, JOHANNESBURG

Public Service Vacancies

1. The attention of Medical Practitioners and Dentists registered with the South African Medical and Dental Council is drawn to an advertisement appearing in the Government Gazettes of 22 and 29 October and 5 November, 1954, inviting applications for the under-mentioned posts in the Public Service.

Post	Salary Scale	Department or Administration
Chief Medical Inspector of Schools (Transvaal Education Department)	£1,680	Transvaal Provincial Administration.
Medical Inspector (Durban)	£1,380	Health.
District Surgeon, Grade III (Laersdrif, Potgietersrus, Bloemfontein, Kimberley, Nylstroom, Durban and Vereeniging)	£1,020x60—1,380	Health.
Medical Officer (Johannesburg)	£1,020x60—1,200	Mines
Dentist (Grassy Park and Stellenbosch)	£1,020x60—1,200	Health. Closing date: 29 November 1954.
Medical Officer (on contract for two years) (Walmer)	£1,020x60—£1380	Health.

2. In addition to salary a cost of living allowance at the rate of £234 per annum is at present payable to married officers.

3. It is emphasised that full particulars of qualifications and experience must be furnished but original certificates and testimonials should not be submitted. Application forms (Z. 83 and P.S.C. 8 (a)) are obtainable from the department/administration indicated to whom filled-in forms must be addressed.

4. The closing date for the receipt of applications is 27 November 1954, except where otherwise indicated.

47629

Provinsiale Administrasie van die Kaap die Goeie Hoop

UNIVERSITEIT VAN KAAPSTAD: GESAMENTLIKE
MEDIESE PERSONEEL VIR GROOTE SCHUUR-EN ANDER
OPLEIDINGSHOSPITALE

VAKATURES

1. Aansoeke word ingewag van geregistreerde Geneeshere (geregistreerde Spesialiste) vir aanstelling tot die volgende poste:

Departement van Narkose:

1 Pos van Geneesheer, Graad D, met salaris volgens die skaal £1,200x50—1,500 per jaar.

Departement van Patologie:

1 Pos van Geneesheer, Graad D, met salaris volgens die skaal £1,200x50—1,500 per jaar.

2. Die diensvoorwaardes word voorgeskryf ingevolge die Ordonnansie op Hospitaalraadsdiens no. 19 van 1941, soos gewysig, en die regulasies wat daarkragens opgestel is.

3. Benewens die salarisskaal soos aangedui is 'n lewenskoste-toelae teen bedrae wat van tyd tot tyd deur die Administrateur vasgestel word aan voltydse beamptes en werknemers betaalbaar.

4. Van die Gesamentlike Mediese Personeel word vereis om die Provinsiale Administrasie van die Kaap die Goeie Hoop en die Universiteit van Kaapstad gesamentlik te dien.

5. Kandidate moet geregistreerde spesialiste wees in die spesialisiteit waarin die vakature bestaan.

6. Aansoek moet gedoen word op die voorgeskrewe vorm (Staf 23), wat verkrygbaar is by die Direkteur van Hospitaaldienste, Posbus 2060, Kaapstad, of by die Mediese Superintendent van enige provinsiale hospitaal of by die Sekretaris van enige skoolraad in die Kaapprovinsie.

7. Die ingevulde aansoekvorms moet aan die Direkteur van Hospitaaldienste, Posbus 2060, Kaapstad, gerig word en moet hom uiters op 30 November 1954 bereik.

8. Die suksesvolle kandidaat vir die pos van Geneesheer, Graad D—Departement van Narkose—moet bereid wees om diens nie later as 7 Februarie 1955 te aanvaar nie.

M129281

The Medical Association of South Africa Die Mediese Vereniging van Suid-Afrika

AGENCY DEPARTMENT : AGENTSAP-AFDELING

JOHANNESBURG

Medical House, 5 Esselen Street. Telephones: 44-9134, 44-0817
Mediese Huis, Esselenstraat 5. Telephone: 44-9134, 44-0817

Tel. Add.: 'Serpent'

PRACTICES AND PARTNERSHIPS OFFERED PRAKTYKE EN VENNOOTSAPPE AANGEBIED

(Pr-S154) Transvaalse dorp, binne maklike bereik van Johannesburg. 'n Assistent met oog op vennootskap word verlang vir 'n goedgevestigde praktyk, wat steeds uitbrei. Goëe aanvang-salaris plus kommissie sal betaal word. Chirurgie word gedoen en iemand met kennis daarvan, sal voorkeur geniet.

(Pr-S153) 'n Vennootskap word aangebied in 'n groot Transvaalse dorp, met groot hospitaal. Hoewel hierdie praktyk oud-gevestig is, brei dit tans nog uit, en kan die eienaar nie al die werk behartig nie. Geen aanstellings word gehou. Alle chirurgie word gedoen en iemand, met nie minder dan ongeveer ses jaar ondervinding, word verkies. Vir iemand wat 'n verplasing na 'n groot dorp, met goëe hospitaal en groot skole, wil maak, is dit 'n goëe geleentheid.

(Pr-S148) Northern Rhodesia. An exceptionally well-organized, high class practice in a large hospital town. Actual cash takings £3,500/£4,000 p.a. Expenses are approximately £750 p.a. Will suit Doctor with surgery and/or gynaecology as background. Practically no country travelling is done. Premium: £1,500 for goodwill, introduction and equipment. Terms could be arranged. In case of an outright sale, an introduction of about 6 months will be given. This doctor also requires a locum to start as soon as possible, and if suitable as Assistantship/Partnership will be offered, with view to succession.

(Pr-S151) Transvaal. 'n Ongeopponeerde praktyk, met twee oordraagbare aanstellings. Die netto inkomste oorskry £2,500 per jaar. Die eienaar is reeds die afgelope 8 jaar in besit van hierdie praktyk. Die werk is nie veeleisend nie, en min nagwerk word gedoen. Huis te huur vir getroude persoon. Die premie is £1,000 en sluit medisyne voorraad en instrumente in. Beste terme denkbaar sal gereël word.

(Pr-S149) Pretoria. Goedgevestigde praktyk met oordraagbare aanstellings van £125 per maand. Privaat praktyk bring 'n verdere £175/£200 p.m. in en hierop kan nog verbeter word. Die premie is £2,000 en sluit meubels, instrumente en medisyne-voorraad in. Terme kan gereël word.

(Pr-S143) Transvaal. Een van die beste vennootskap-praktyke, word as 'n geheel te koop aangebied. Aanstellings aan die praktyk verbonde beloop ongeveer £3,500 per jaar. Die netto inkomste van die praktyk is £7,000 per jaar. Die premie is £3,000 en sluit alle medisyne en meubels in. Dit is van belang dat twee geneesheer hierdie praktyk saam koop, in welke geval elkeen £1,500 betaal. Terme kan gereël word. Volle besonderhede op aanvraag.

(Pr-S134) Transvaal. Partner is required with view to succession. Old-established dispensing, practice. Gross income over £4,000 p.a. House available to rent or to buy. Excellent opportunity for an Afrikaans speaking doctor to acquire a sound partnership/practice, with appointments. Small initial capital required.

(Pr-S125) Noord-Vrystaat. Groot hospitaaldorp, met goëe skole. 'n Goedgevestigde praktyk met 'n netto inkomste van oor £4,000 p.j. Praktyksonkoste aansienlik laag. Eienaar onderneem alle chirurgie. Een oordraagbare aanstelling van £26 p.m. Die premie is £2,500 en kan as volg afbetaal word: £1,000 kontant en balans teen £50 per maand. Dit sluit alle spreekkamertoerusting in.

(Pr-S136) Vrystaat. 'n Praktyk geskik vir twee jong geneesheer, wat saam wil praktiseer. 'n Ou-gevestigde praktyk met 'n aanstelling wat ongeveer £1,000 per jaar inbring. Die gemiddelde jaarlikse inkomste is £4,700/£4,900. Praktyksonkoste is baie laag. Spreekkamers te huur teen £8 5s. 0d. per maand en 'n gerieflike woning teen £12 p.m. Eienaar doen geen snykunde nie, en alhoewel dit gedoen kan word, sal die praktyk 'n Internis, uitstekend pas. Premie is £2,000 en terme kan gereël word.

(Pr-S141) Johannesburg. Non-European practice, with two surgeries in excellent positions. No night work and no weekend work. Cash takings average £250 p.m. Expenses under £90 per

month. This proposition will definitely suit someone wishing to expand or a beginner.

* * *

KAAPSTAD : CAPE TOWN

Posbus 643, Telefoon 2-6177 : P.O. Box 643, Telephone 2-6177
Waalstraat 35 : 35, Wale Street

PRAKTYKE TE KOOP : PRACTICES FOR SALE

(1276) S.W.A. hospital town. Well-established prescribing practice. Cash income=£3,879 p.a. THIS IS AN EXCELLENT OPPORTUNITY to acquire a very good practice with full scope for surgery at an exceptionally low premium as the owner wishes to sell as soon as possible in order to specialize. Premium for goodwill, instruments and excellent surgery furniture £1,600. Terms possible.

(1790) Transkei practice. Two appointments. Receipts for year 1953/54 £4,220. Premium of £2,000, includes drugs, surgery furniture, instruments, etc. Payment could be made in instalments. A well built house available.

(1765) Noord-Kaapland. Praktyk sonder opposisie. Verpleeg-irrigating plaaslik. Distriks- en Spoorweggeneesheer. Premie vir klandisiewaarde, meubels, medisyne en instrumente ongeveer £800-£900. Betaling in paaiemente aanvaarbaar.

ASSISTENTE: PLAASVERVANGERS VERLANG ASSISTANTS: LOCUMS REQUIRED

LOCUMS AND OR ASSISTANTS ARE URGENTLY REQUIRED FOR URBAN AND RURAL AREAS. DETAILS ON APPLICATION.

INSTRUMENTS FOR SALE

(1587) Zeiss Winkler Microscope (91385) with 3 lenses. Oil immersion and 2 eyepieces £60. Haemacytometer £3.16.0.

These instruments are NEW but available at reduced prices.

(1681) Urological instruments at greatly reduced prices.

* * *

DURBAN

112 Medical Centre, Field Street. Telephone 2-4049

PRACTICES FOR SALE

(PD28) Durban. General practice also non-European surgery. Owing to ill-health owner wishes to sell as soon as possible. Before illness gross income £3,000 per annum. Premium £2,000. House for sale.

(PD30) Durban. European prescribing practice. Total gross receipts average over £2,000 per annum. Good class practice, bad debts negligible. Premium £2,650. Transfer and introduction by mutual arrangement. Seller intends specialising.

(PD31) Natal Inland. Unopposed prescribing practice mainly Native. Monthly cash receipts average £450. Premium required £2,500 includes surgery, furniture and instruments. House for sale. All sporting facilities.

LOCUMS REQUIRED

(W14) Locum from 1 January 1955 for one year. Salary to be discussed. Natal general country practice with small amount of surgery and midwifery. Furnished house available. Must have own car.

(SV5) Locum for January. £3 3s. per day plus board and lodging. £10 car allowance and petrol. Natal Hospital town. Travelling allowance to and from practice for reasonable distance.

(LD6) from 8 to 23 January 1955. Natal. Mainly non-European dispensing with mine Hospital appointment. Own car necessary. £3 3s. per day, all found.

(FK7) From 1 October for 6 months. Natal general practice. £3 3s. per day, all found. Must have own car.

ASSISTANT REQUIRED

(AM2) Assistant required for trial period. If suitable partnership will be offered. General practice in select area approximately 20 miles from Durban.

(AM4) ASSISTANT WITH VIEW. TERMS TO BE ARRANGED OR LOCUM DURING FOUR MONTHS ABSENCE OF ONE PARTNER. COUNTRY PRACTICE NEAR PIETERMARITZBURG. £3 3s. 0d. per day, all found. Car essential. IMMEDIATELY.

INSTRUMENTS FOR SALE

Two Electrocardiograph machines in first class order. Owner acquiring self-reading machine. Offers to be made.
 Davidson Pneumothorax apparatus. Practically new. Any offer considered.
 Super-sonic (Impulsaphon) Machine in perfect condition. £250 immediate sale.

Departement van Mynwese

**VAKATURE VIR MEDIESE BEAMPTTE : ALLUVIALE
 STAATSDIENST, ALEXANDERBAAI : SALARIS :
 £1,380 P.J. (VAS)**

VERWYSINGSNUMMER : STAF 1/28/7

1. Aansoek om aanstelling in bogenoemde pos op die diensstaat van die Alluviale Staatsdiens, Alexanderbaai, Namakwaland, word ingewag.

2. Die betrekking is voltyds en die bekleeër van die pos sal ingevolge die bepaling van die Regeringsdienspensioenwet, No. 32 van 1936, soos gewysig, moet bydra tot die Regerings-werknemersondersteuningsfonds. In die geval van 'n persoon sonder afhanklikes, word rantsoene en inwoning, en in die geval van 'n persoon wie se afhanklikes by hom inwoon, word 'n huis en redelike hoeveelhede water en elektriese krag gratis verskaf.

3. Kandidate moet Suid-Afrikaanse burgers of burgers van 'n Statebondslid van die Republiek Ierland en tweetalig wees, moet minstens drie jaar in die Unie van Suid-Afrika of in Suidwes-Afrika gewoon het en geregistreerde mediese praktisyns wees. Voorkeur sal aan 'n kandidaat wat in besit van die Diploma in Volksgegesondheid is, gegee word. Kennis van X-straalwerk sal 'n aanbeveling wees.

4. Die suksesvolle applikant sal verantwoordelik wees vir die welsyn van die gemeenskap te Alexanderbaai en sal chirurgiese werk moet onderneem. Die plaaslike hospitaal (32 beddens) is goed met moderne mediese apparaat uitgerus. Daar bestaan ontpanningsgeriewe.

5. Benewens die salaris soos aangedui, sal 'n lewenskoste-toelaag teen die Staatsdienstarief, wat tans £234 per jaar bedra, in die geval van 'n getroude persoon betaalbaar wees.

6. Die suksesvolle kandidaat moet 'n bevredigende geboorteen- en gesondheidsertifikaat indien en moet 'n dienskontrak aangaan waarvan 'n voorbeeld deur die Sekretaris van Mynwese op aanvraag verskaf sal word.

7. Oorspronklike sertifikate en getuigskrifte moet vir eers nie ingedien word nie, maar volledige besonderhede betreffende kwalifikasies en vorige ondervinding moet verstrek word.

8. Daar moet aansoek gedoen word op die voorgeskrewe vorm Z. 83 wat verkrygbaar is van die Sekretaris van Mynwese, Vanderstelgebou, Pretoriusstraat, Pretoria, aan wie die ingevulde vorms gerig moet word. Genoemde vorms is ook by alle magistraatskantore verkrygbaar.

9. Die sluitingsdatum vir die ontvangs van aansoeke is 15 November 1954.

10. Telefoniese navrae kan aan nr. 2-3510, Pretoria, gerig word. 47426

ASSISTENT BENODIG

Assistent dringend benodig in gevestigde plattelandse tweeman-praktyk met D.G. en S.A.S. aanstellings. Vooruitsig tot vennootskap indien geskik, binne kort tyd. Snykunde-ondervinding sal 'n aanbeveling wees. £3 3s. 0d. per dag plus reistoelae. Moet eie motor hê. Doen aansoek A.W.P., Posbus 643, Kaapstad.

LOCUM REQUIRED

Locum required for partnership 1 January to end of February 1955. Own car not essential, £3 3s. 0d. per day, all found. Eastern Free State. Apply A.W.O., P.O. Box 643, Cape Town.

Ondersteun Asseblief Ons Adverteerders

Please Support Our Advertisers —

Provinsiale Administrasie van die Kaap

Die Goeie Hoop

HOSPITAALDEPARTEMENT**HOSPITAALRAADSDIENS : VAKATURES**

1. Aansoek word ingewag van geregistreerde geneeshere vir aanstelling tot die volgende vakante pos:

Afdeling	Pos	Hospitaal	Salarisskaal	Sluitings- datum
Professionele en Tegniese	Geneesheer, Graad A	Sir Henry Elliot- hospitaal Umtata	£500—600— 660—720 p.j.	13.11.54

Aansoek moet aan die Mediese Superintendent gerig word.

2. Die diensvoorwaardes word voorgeskryf ingevolge die Ordonnansie op Hospitaalraadsdiens nr. 19 van 1941, soos gewysig, en die regulasies wat daarkragtens opgestel is.

3. Benewens die salarisskaal soos aangedui is 'n lewenskoste-toelae betaalbaar aan voltydse beamptes en werknemers teen bedrae wat van tyd tot tyd deur die Administrateur vasgestel word.

4. Die geslaagde kandidaat indien nie reeds in die Hospitaal-raadsdiens nie, moet bevredigende geboorteen- en gesondheids-certifikate indien.

5. Aansoek moet gedoen word op die voorgeskrewe vorm (Staf 23) wat verkrygbaar is by die Direkteur van Hospitaaldienste, Posbus 2060, Kaapstad, of by die Mediese Superintendent van enige provinsiale hospitaal of by die Sekretaris van enige Skoolraad in die Kaapprovinsie.

6. Kandidate moet die vroegste datum meld waarop hulle diens kan aanvaar. M129287

Provinsiale Administrasie van die Kaap

die Goeie Hoop

HOSPITAALDEPARTEMENT**SHARLEY CRIBB-VERPLEGINGSKOLLEGE, PORT****ELIZABETH: LESINGS VIR LEERLINGVERPLEEGSTERS**

Aansoek word ingewag van geregistreerde geneeshere om lesings aan leerlingverpleegsters aan die Sharley Cribb-verplegingskollege, Port Elizabeth, te gee oor die volgende onderwerpe vir 'n tydperk van drie jaar, met ingang van 1 Desember 1954:

3 kursusse per jaar	
Narkoseleer, Engels en Afrikaans	3 lesings per kursus
Kindersiektes, Engels en Afrikaans	8 lesings per kursus
Urologie, Engels en Afrikaans	5 lesings per kursus
Ginekologie, Engels en Afrikaans	6 lesings per kursus
Oor, Neus en Keel, Engels en Afrikaans	3 lesings per kursus
Oogheelkunde, Engels en Afrikaans	3 lesings per kursus
Dermatologie, Engels en Afrikaans	3 lesings per kursus
Veneriese Siektes, Engels en Afrikaans	3 lesings per kursus
Anatomie, Engels en Afrikaans	25 lesings per kursus
Fisiologie, Engels en Afrikaans	25 lesings per kursus
Mediese Verpleging, Engels en Afrikaans	40 lesings per kursus
Chirurgiese verpleging, Engels en Afrikaans	40 lesings per kursus
Ortopedies (Beenkunde), Engels en Afrikaans	12 lesings per kursus
Artsenykunde, Engels en Afrikaans	12 lesings per kursus

Lesings moet tussen die ure 8 vm. en 3 nm. daaglik gegee word. Elke lesing sal een uur duur.

Lektore sal teen £1 1s. 0d. per lesing besoldig word.

Nadere besonderhede is verkrygbaar by die Prinsipale, Sharley Cribb-verplegingskollege, Park Drive, Port Elizabeth.

Kandidate moet meld oor watter onderwerpe hulle bereid is om lesings te gee, en of hulle lesings in Engels of Afrikaans of beide tale kan gee.

Aansoek moet gedoen word op die voorgeskrewe vorm Staf 23 wat verkrygbaar is by die Direkteur van Hospitaaldienste, Posbus 2060, Kaapstad, of by die Mediese Superintendent van enige Provinsiale hospitaal of by die Sekretaris van enige Skoolraad in die Kaapprovinsie, en ook by die Prinsipale, Sharley Cribb-verplegingskollege, Park Drive, Port Elizabeth.

Aansoek moet aan die Direkteur van Hospitaaldienste, Posbus 2060, Kaapstad, gerig word en moet hom uiters op 13 November 1954 bereik. M129282

Transvaalse Provinsiale Administrasie

VAKATURES BY PUBLIEKE HOSPITALE

Aansoeke word ingewag van kandidate met geskikte kwalifikasies vir die onderstaande poste by Publieke Hospitale in die Transvaal.

Aansoeke moet gerig word aan die Geneeskundige Superintendent of Verantwoordelike Geneesheer van die betrokke hospitaal en moet volle besonderhede bevat aangaande die ouderdom, professionele, akademiese en taalkwalifikasies, ondervinding en huwelikstaaf van die applikant en moet voorts 'n aanduiding bevat van die vroegste datum waarop diens aanvaar kan word. Afskrifte van onlangse getuigskrifte moet aangeheg word by aansoeke.

Lewenskostetoelae tans betaalbaar aan voltydse werknemers:

Salaris	Getroud	Ongetroud
Oor £350 per jaar	£352 per jaar	£110 per jaar.

Van persone wat aangestel word, sal verwag word om bevredegende sertifikate in te dien, asook om hulle te onderwerp aan 'n geneeskundige ondersoek by die betrokke hospitaal.

Aansoekvorms is verkrygbaar van enige Transvaalse Publieke Hospitaal of die Provinsiale Sekretaris, Afdeling Hospitaaldienste, Posbus 2060, Pretoria.

Benewens jaarlikse salaris en lewenskostetoelae ontvang voltydse werknemers spoorwegkonsessie en word verlof toegestaan ooreenkomstig die hospitaal-verlofregulasies.

Die sluitingsdatum van aansoek vir die poste is 17 November 1954.

Pos	Hospitaal	Emolumente	Aanmerkings
Senior Neuro-Chirurg	Pretoria	£2,000 per jaar	Geregistreerde Mediese Praktisyn, met ondervinding in Neuro-Chirurgie. Voorkeur sal gegee word aan Geregistreerde Spesialiste in Neuro-Chirurgie.
Narkotiseur	Coronation, Johannesburg en die Universiteit van die Witwatersrand	£1,800 per jaar	Geregistreerde Mediese Praktisyn. Hoër graad in Narkose.
Internis (Doserend)	Algemeen, Johannesburg	£1,800 per jaar	Geregistreerde Mediese Praktisyn met kwalifikasies in Narkose.
Assistent-Chirurg	Coronation, Johannesburg en die Universiteit van die Witwatersrand	£1,200x50—1,500	Geregistreerde Mediese Praktisyn. Hoër graad in Chirurgie 'n aanbeveling.
Assistent Plastiese Chirurg	Algemeen, Johannesburg	£1,200x50—1,500	Geregistreerde Mediese Praktisyn. Hoër graad in Chirurgie 'n aanbeveling.
Deeltydse Ortopediese Chirurg	Coronation, Johannesburg en die Universiteit van die Witwatersrand	£684 per jaar 3 sessies per week	Geregistreerde Mediese Praktisyn. Hoër graad in Ortopedie 'n vereiste.
Deeltydse Senior Tandarts	Tam, Johannesburg	£456 per jaar 2 sessies per week	Gekwalifiseerde tandarts.
Paediatrisie Registrateur	Coronation, Johannesburg en die Universiteit van die Witwatersrand	£620-780-820-860	Geregistreerde Mediese Praktisyn. Moet minstens twee jaar gekwalifiseerd wees.

Pos	Hospitaal	Emolumente	Aanmerkings
Narkotiseur Registrateur	Boksburg-Benoni	£620-780-820-860	Geregistreerde Mediese Praktisyn. Moet minstens twee jaar gekwalifiseerd wees.
	Germiston	£620-780-820-860	do.
Chirurgiese Registrateur	Coronation, Johannesburg en die Universiteit van die Witwatersrand	£620-780-820-860	Moet ondervinding in toediening van Narkose hê. Geregistreerde Mediese Praktisyn. Moet minstens twee jaar gekwalifiseerd wees.
Mediese Registrateur	Coronation, Johannesburg en die Universiteit van die Witwatersrand.	£620-780-820-860	do.
Kliniese Assistent	Vereeniging	£620-780-820-860	do.
	Warmbad Nie-Akute Vereniging	£620-780-820-860	do.
Kliniese Assistent (Narkose)		do.	do.
Kliniese Assistent (Neuro-Chirurgie)	Pretoria	£620-780-820-860	do.
Mediese Beampte	Verre Oosrand, P.K. New State Areas	£620-780-820-860	Geregistreerde Mediese Praktisyn.
Ongevalle Beampte	Coronation, Johannesburg en die Universiteit van die Witwatersrand.	£620-780-820-860	do.
	Ontdekkers Gedenk P.K. Florida. Vereniging	£620-780-820-860	do.
	Verre Oosrand, P.K. New State Areas	£620-780-820-860	do.
Senior Huisdokter	Witbank	£480 per jaar. Plus losies en inwoning of 'n toelae van £120 per jaar ten opsigte van losies en inwoning.	Geregistreerde Mediese Praktisyn.
	Pretoria.	£480 per jaar. Plus losies en inwoning of 'n toelae van £120 per jaar ten opsigte van losies en inwoning.	do.
Senior Huisdokter (Neuro-Chirurgie)		£480 per jaar. Plus losies en inwoning of 'n toelae van £120 per jaar ten opsigte van losies en inwoning.	do.
Senior Huisdokter	Vereeniging	£480 per jaar. Plus losies en inwoning of 'n toelae van £120 per jaar ten opsigte van losies en inwoning.	do.

Pos	Hospitaal	Emolumente	Aanmerkings
	Verre Oosrand, P.K. New State Areas	£480 per jaar. Plus losies en inwoning of 'n toelae van £120 per jaar ten opsigte van losies en in- woning.	do.
OF Intern	Vereeniging	£240 per jaar. Plus losies en inwoning of 'n toelae van £120 per jaar ten opsigte van losies en in- woning.	—
	Verre Oosrand, P.K. New State Areas	do.	—
Intern	Witbank	£240 per jaar. Plus losies en inwoning of 'n toelae van £120 per jaar ten opsigte van losies en in- woning.	—

47512

Provinsiale Administrasie van die Kaap die Goeie Hoop

UNIVERSITEIT VAN KAAPSTAD : GESAMENTLIKE
MEDIESE PERSONEEL VIR GROOTE SCHUUR- EN ANDER
OPLEIDINGSHOSPITALE

VAKATURES

1. 'n Aantal deeltydse sessies bestaan in die Verloskunde- en Ginekologie-departement by die bogenoemde inrigting en aansoek word ingewag van Geregistreerde Geneesheer (Geregistreerde Spesialiste) vir aanstelling tot hierdie deeltydse poste:

Departement van Verloskunde en Ginekologie

Graad, G' salaris teen £182 per jaar per sessie.

Graad, F' salaris teen £164 per jaar per sessie.

Graad, E' salaris teen £146 per jaar per sessie.

Graad, D' salaris teen £110 per jaar per sessie.

2. Die diensvoorwaardes word voorgeskryf ingevolge die Ordonnansie op Hospitaalraadsdiens no. 19 van 1941, soos gewysig, en die regulasies wat daarkragtens opgestel is.

3. Van die Gesamentlike Mediese Personeel word vereis om die Provinsiale Administrasie van die Kaap die Goeie Hoop en die Universiteit van Kaapstad gesamentlik te dien.

4. Kandidate moet die aantal sessies wat hulle gewillig sal wees om te onderneem en ook die Graad waarin hulle aanstelling verlang, meld.

5. 'n Sessie is vier uur per week in verband met kliniese en/of opleidingswerk, maar is nie noodwendig onafgebroke nie.

6. Kandidate vir die Graad G, F en E poste moet minstens drie jaar ondervinding na registrasie as 'n Spesialis in die spesialiteit waarin die vakature bestaan, opgedoen het.

7. Kandidate vir die Graad D pos moet geregistreerde spesialiste wees in die spesialiteit waarin die vakature bestaan.

8. Aansoek moet gedoen word op die voorgeskrywe vorm (Staf 23), wat verkrygbaar is by die Direkteur van Hospitaaldienste, Posbus 2060, Kaapstad, of by die Mediese Superintendent van enige provinsiale hospitaal of Sekretaris van enige Skoolraad in die Kaapprovinsie.

9. Die ingevulde aansoeksvorms moet aan die Direkteur van Hospitaaldienste, Posbus 2060, Kaapstad, gerig word, en moet hom nie lateras 20 November 1954 bereik nie.

M129288

Provincial Administration of the Cape of Good Hope

HOSPITALS DEPARTMENT

1. Applications are invited from Medical Graduates for appointment to posts of Junior Resident Medical Officer (Intern) at the under-mentioned institutions:

Conradie Hospital, Pinelands	5 posts
False Bay Hospital, Simonstown	1 post
Groote Schuur Hospital, Observatory, Cape	—
Mowbray Maternity Hospital, Mowbray, Cape	2 posts
Peninsula Maternity Hospital, Cape	3 posts
Rondebosch and Mowbray Hospitals, Cape	2 posts
Victoria Hospital, Wynberg, Cape	4 posts
Somerset Hospital, Green Point, Cape	10 posts
Woodstock Hospital, Woodstock, Cape	3 posts
Frere Hospital, East London	10 posts
Settlers' and Prince Alfred Hospital, Grahams-town	2 posts *
Victoria Hospital, Lovedale	6 posts *
Paarl Hospital, Paarl	1 post *
Provincial Hospital, Port Elizabeth	8 posts *
Sir Henry Elliot Hospital, Umtata	5 posts *
Livingstone Hospital, Port Elizabeth	11 posts *
Frontier Hospital, Queenstown	3 posts *

* Contract period with effect from 1 January 1955.

2. The salary attaching to a post of Junior Resident Medical Officer (Intern) is £240 per annum plus board, quarters and laundering.

3. In addition to the salary and allowances stated above, a temporary non-pensionable cost-of-living allowance is payable at rates and on the conditions that may be prescribed by the Administrator from time to time.

4. Candidates applying for more than one post should submit separate applications and copies of testimonials for each post applied for.

5. Candidates writing the final M.B., Ch.B. examinations can submit their applications prior to the results of the examination being known.

6. Successful candidates will be required to enter into contracts with the Provincial Administration with effect from 16 January 1955 (unless otherwise stated) and must be registered with the South African Medical Council before they will be allowed to assume duty.

7. Candidates who wish to enter as interns at Groote Schuur Hospital, Cape Town, should state:

(1) Whether they are prepared to accept any internship which is offered them; and

(2) indicate their preference for the following Departments by marking against them 1, 2, 3, etc.

(a) General Medicine.

(b) General Surgery.

(c) Gynaecology and Obstetrics.

(d) Other departments to be specified by applicants.

It is intended that appointees will rotate within one or several of the above departments.

8. The appointment will be in terms of and subject to the provisions of Ordinance No. 19 of 1941, as amended, and the regulations framed thereunder.

9. The application must be made on the prescribed form (Staff 23) which is obtainable from the Director of Hospital Services, P.O. Box 2060, Cape Town, or from the Medical Superintendent of any Provincial Hospital or Secretary of any School Board in the Cape Province.

10. The completed forms must be forwarded to reach the Medical Superintendent of the institution concerned not later than 27 November, 1954.

M129289

WHY NOT MAKE YOUR STOCK EXCHANGE INVESTMENTS MORE PROFITABLE . . .

by taking advantage of the information and advice contained in the Weekly Confidential Letters posted airmail every Tuesday by the STOCK EXCHANGE ADVISORY SERVICE?

A Member in Natal, following the advice of the STOCK EXCHANGE ADVISORY SERVICE, has just made £15,000 profit on a £2,000 capital during three years trading in Stock Exchange Shares. Subscription for 26 Weekly Confidential Letters £4/4/- includes a reprint of recent Chamber of Commerce address "Stock Exchanges in the Atomic Era" by Mr. Pessach.

Membership applications to Mr. Pessach, Share Consultant, P.O. Box 3084, Cape Town.

Vacant Part-time District Surgeoncies

Applicants for the under-mentioned district surgeoncies accompanied by full particulars as to date and country of birth, qualifications, experience, previous and present appointments of the applicants and the earliest date on which they can assume duty, if appointed, should reach the Secretary for Health, P.O. Box 386, Pretoria, not later than 17 November 1954, copies of testimonials may be submitted.

Canvassing by or on behalf of any applicant is liable to disqualify him.

The appointments are on a part-time basis and private practice is not precluded.

Applicants should state whether they have knowledge of both official languages, also whether they are competent to diagnose leprosy and venereal diseases.

Applicants should also state whether they have any experience as a Medical Officer of Health or in any similar capacity. If more than one post is applied for, a separate application should be submitted in respect of each.

Place	Salary per annum	Drug allowance per annum
Cape Province:	£	£
Brandvlei	250	30
Indwe	175	20
Pearston	200	25
Port Alfred	250	15
Rhodes	350	25
Tabankulu	350	10
Ugie	180	20
Villiersdorp	90	20
Transvaal:		
Alldays	350	25
Soekmekaar	560	75
Orange Free State:		
Hertzogville	230	40
Springfontein	170	50
Natal:		
Ingwavuma	750	50
Richmond	300	10

The salaries cover all ordinary and routine services but travelling allowance of 1s. per mile for all mileage travelled outside a radius of three miles from headquarters, night detention at 15s. and supplementary fees for certain other services will be payable, also fees for attendance at courts and inquests in accordance with the tariff of the Department of Justice.

Forms of application and copy of draft agreement will be furnished on application.

47613

Provincial Administration of the Cape of Good Hope

LIVINGSTONE HOSPITAL : PORT ELIZABETH VACANCIES : HONORARY MEDICAL STAFF

Applications are invited from registered medical practitioners for appointment to the under-mentioned vacancies on the Honorary Staff of this Institution.

The appointment, which is subject to the Hospital's Ordinance No. 18 of 1946 (Cape), as amended, and the regulations framed thereunder, will expire on the first anniversary of the date on which the Medical Committee for this hospital is elected.

Applications, which must be made on the prescribed form, Staff 23, must be submitted to the Medical Superintendent, Livingstone Hospital, Port Elizabeth, to reach his office not later than 27 November 1954.

Designation	Department	No. of Posts
First Assistant Surgeon ..	Surgery ..	1
Clinical Assistant	Dermatology ..	1
Senior Honorary Paediatrician ..	Paediatrics ..	1
Honorary Paediatrician ..	Paediatrics ..	1
Clinical Assistant	Paediatrics ..	2
Assistant Obstetrician and Gynaecologist	Obstetrics and Gynaecology ..	2
Clinical Assistant	Obstetrics and Gynaecology ..	1

Livingstone Hospital
Port Elizabeth
14 October 1954

J. L. G. Ware
Medical Superintendent

4641

Provinsiale Administrasie van die Kaap die Goeie Hoop

LIVINGSTONE-HOSPITAAL : PORT ELIZABETH VAKATURE : ERE-MEDIESE PERSONEEL

Aansoeke word ingewag van geregistreerde geneeshere vir aanstelling tot die onbevestigde vakante betrekkinge op die personeel van hierdie hospitaal.

Die aanstelling, wat onderworpe is aan die Hospitaal Ordonnansie no. 18 van 1946 (Kaap) soos gewysig, en die regulasies wat daarteenafgevolg opgestel is, sal verstryk twaalf maande na die datum waarop die Mediese-Komitee vir hierdie hospitaal verkies is.

Aansoeke, wat op die voorgeskrewe vorm, Staf 23, gemaak, en gerig moet word, aan die Mediese Superintendent, Livingstone Hospitaal, Port Elizabeth, moet sy kantoor nie later as 27 November 1954 bereik nie.

Benaming	Afdeling	Aantal Poste
Eerste Assistent Chirurg ..	Chirurgies ..	1
Kliniese Assistent	Dermatologie ..	1
Senior Ere Kindersiekkundige ..	Kindersiektes ..	1
Ere Kindersiekkundige	Kindersiektes ..	1
Kliniese Assistent	Kindersiektes ..	1
Assistent Verloskundige en Ginekoloog	Verloskunde en Ginekologie ..	2
Kliniese Assistent	Verloskunde en Ginekologie ..	1

Livingstone Hospitaal
Port Elizabeth
14 Oktober 1954

J. L. G. Ware
Mediese Superintendent

4641



X-RAY APPARATUS

by

MARCONI

(SOUTH AFRICA) LTD.

UNION CORPORATION BLDG., MARSHALL ST., JOHANNESBURG

Also Cape Town and Durban

RADIO COMMUNICATIONS • NAVIGATIONAL AIDS • TELEVISION AND SOUND
BROADCASTING • INDUSTRIAL AND LABORATORY ELECTRONIC INSTRUMENTS
X-RAY AND ELECTROMEDICAL EQUIPMENT

Most skin lesions respond to **FISSAN**

THE CLINICAL USE OF FISSAN SKIN PREPARATIONS

FISSAN powders have a remarkable ability to adhere to the skin and their exceedingly fine texture ensures skin protection without clogging the pores.

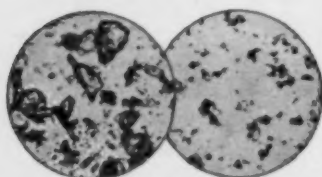
FISSAN powders absorb moisture and have a drying, cooling effect.

FISSAN powders are deodorant, lubricant and give protection against the effect of friction and occupational skin troubles.

FISSAN powders reduce inflammation and irritation and have a positive healing effect.

References:

1. Goodman, H.: Statistics of the Ten Most Common Skin Diseases, Arch. Dermat. and Syph. 20: 186, August, 1929.



Left:

Ordinary Dusting Powder—Particle size varies, distribution is uneven and texture coarse.

Right:

Fissan Dusting Powder—Note even distribution and fine particle size

Further information from:
BRITISH CHEMICALS & BIOLOGICALS (S.A.) (PTY.) LTD.
259 COMMISSIONER STREET
P.O. Box 5788 JOHANNESBURG

Statistics show that ten dermatoses account for over 75 per cent of skin conditions seen in clinical and private practice and of these eczema and acne amount to approximately one-third.¹

In the local treatment of most cutaneous diseases one of the FISSAN skin products will find a place of value. The clinician is able to use his discretion by prescribing Fissan Paste as an emollient or Fissan Ichthammol Powder for its more drying effect. Either may be employed to act as a vehicle for other medicaments.

FISSAN products are not only superior merely because they are more elegant, but because the FISSAN method has been evolved from exhaustive studies of skin healing based on the principle that skin responds best to a mild form of treatment. No corrosive antiseptics or irritant medicaments, therefore, are used, but only those which are known to be without exacerbating effect.

FISSAN products depend for their effect on two essential ingredients — colloidal milk albumin and fluorosilica colloid (a dispersing agent with a high covering power). Itching and inflammatory conditions are soothed by the natural anti-pruritic affect of lactalbumin and fluorosilica colloid enables the skin to remain pliable and soft and to lose heat or moisture without any exudate forming a crust.

Whenever an inflammatory process has given rise to erythematous, scaling, papular, exudative, vesicular, itching or burning reactions, in the skin, the correct FISSAN preparation will bring rapid improvement.

FISSAN PREPARATIONS

Preparation	Indications	Packs
'FISSAN' ICHTHAMMOL POWDER (2% Ichthammol - 'FISSAN' Dusting Powder base, flesh-tinted).	Acne vulgaris; feet powder; napkin rash; massage powder.	Sprinkler tin. 85 grammes
'FISSAN' DUSTING POWDER.	Intertriginous affections; toilet and nursery use; use with surgical appliances, elastic hosiery, etc.	Sprinkler tin. 85 grammes
'FISSAN' PASTE.	Broken chilblains; dry eczema; minor burns and scalds; chaps and fissures; napkin rash.	Tube—20 grammes Jar—45 grammes
'FISSAN' ANAL OINTMENT.	Anal pruritus; anal fissures.	Tube 20 grammes
'FISSAN' ANAL SUPPOSITORIES.	For relief of irritation, pain and mucus exudation in haemorrhoidal conditions.	Box of 6 Box of 12